DOCUMENT RESUME

ED 169 802 HE 011 056

TITLE	Licensure and Credentialing. Proceedings ANA Conference for Members and Professional Employees of State Boards of Nursing and ANA Advisory Council (Detroit, Michigan, April 27-28, 1972).
INSTITUTION	American Nurses' Association, Kansas City, Mo.
PUB DATE	74
NOTE	37p.
AVAILABLE FROM	American Nurses' Association, 2420 Pershing Road, Kansas City, MO 64108 (B-37-1500, $2.50 per copy, 20 percent discount for 10 or more)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	Accreditation (Institutions); *Certification; *Credentials; Evaluation Criteria; Federal Legislation; Federal Regulation; *Health Occupations; Higher Education; Nurses; *Nursing; Professional Associations; *State Licensing Boards
IDENTIFIERS	*American Nurses Association

ABSTRACT

Proceedings are presented from the American Nursing Association (ANA) conference for members and professional employees of state boards of nursing and the ANA advisory council. In addition to opening remarks and discussion comments, the following papers are presented: "The DHEW Secretary's Report on Licensure: A Summary," by Ronald J. Wylie; "A Study of Accreditation of Selected Health Education Programs: A Report," by William K. Selden; "Nursing Vis-A-Vis Medicine: A Proposal for Legislation," by Marvin S. Fish; "A Discussion of Occupational Licensing," by Charles E. Harmon; "The DHEW Report on Licensure: A Commentary," by Helen V. Connors; and "Remarks by Chairman, ANA Council of State Boards of Nursing," by Hazel Peeples. The first article summarizes the following departmental actions spelled out in the DHEW report: expanded information base and additional consulting capacity, review of health services and training programs, additional accreditation studies, and determination of the feasibility of a national health professions certification system. The second article concerns accreditation of 15 health fields including the following: radiologic technology, medical laboratory assistants, and medical record librarians. The third article discusses the following sources for answers to the question of what is within the scope of nursing practice: opinions of attorneys general, judicial decisions, private counsel, individual and joint statements of professional associations, national commission for the Study of Nursing Education, and other associations. (SW)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED169802

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Emerson

Duren Cox

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND THE ERIC SYSTEM CONTRACTORS."

Proceedings
ANA Conference for
Members and Professional Employees of
State Boards of Nursing
and ANA Advisory Council

April 27-28, 1972 / Detroit, Michigan

Sponsored by the American Nurses' Association
Council of State Boards of Nursing

Copyright © American Nurses' Association, 1974

COMMITTEE ON PROGRAM

Executive Committee of ANA Council of
State Boards of Nursing

Hazel Peeples, R.N., Florida, Chairman

Mildred Frederickson, R.N., Tennessee, Vice-Chairman

Eula Benton, R.N., Kansas

Michael Buggy, R.N., California

Marguerite Hastings, R.N., New Hampshire

Adele Stahl, R.N., Wisconsin

CONTENTS

FIRST SESSION / Thursday Morning, April 27, 1972

Opening Remarks
Hazel M. Peeples 1
Greetings
Hildegard Peplau 1
Eileen Jacobi 1
Remarks by the Presiding Officer
Mildred Frederickson 1
The DHEW Secretary's Report on Licensure: A Summary
Ronald J. Wylie 1
Discussion 7
A Study of Accreditation of Selected Health Educational Programs: A Report
William K. Selden 8
Discussion 11

SECOND SESSION / Thursday Afternoon, April 27, 1972

Remarks by the Presiding Officer
Michael Buggy 14
Nursing Vis-A-Vis Medicine: A Proposal For Legislation
Marvin S. Fish 14
Discussion 17
A Discussion of Occupational Licensing
Charles E. Harmon 19
Discussion 21

THIRD SESSION / Friday Morning, April 28, 1972

Remarks by Presiding Officer
Marguerite Hastings 23
The DHEW Report on Licensure: A Commentary
Helen V. Connors 23
Discussion 25
Remarks by Chairman, ANA Council of State Boards of Nursing
Hazel Peeples 28
Free Discussion 28

FIRST SESSION / *Thursday Morning, April 27, 1972*

The 1972 Conference for Members and Professional Employees of State Boards of Nursing and the ANA Advisory Council convened at 9:15 a.m. on Thursday, April 27, in the Versailles Room of the Pontchartrain Hotel, Detroit, Michigan.

The presiding officers at the opening session were Hazel M. Peeples, Florida, Chairman of the Council of State Boards of Nursing and Mildred H. Frederickson, Tennessee, Vice Chairman of the Council of State Boards of Nursing.

MISS PEEPLES: On behalf of the Council members, I welcome each of you to our Educational Conference, particularly as this is the twenty-fifth anniversary of the Council.

Members of the Executive Committee of the Council are Mildred Frederickson, Vice Chairman, Eula Benton, Michael Buggy, Marguerite Hastings, Adele Stahl and I am Hazel Peeples, Chairman.

Lillian Davidsen, a staff member of ANA, is coordinator of the State Boards of Nursing Unit.

The President of the American Nurses' Association, Dr. Hildegard Peplau, will bring us greetings.

DR. PEPLAU: Ladies and gentlemen, it is a great pleasure for me to address such an important leadership group. I think it is a wonderful opportunity for all of you to come together and discuss this terribly important item, the matter of licensure in nursing. I hope that you will have a very successful conference, that you will be able to generate some important conclusions which will advance the profession and that you will be able to clarify this issue.

I bring you the greetings of the Board of Directors and look forward to hearing the results of your discussion. I am exceedingly pleased to be able to participate in this conference for these two days. Thank you very much.

MISS PEEPLES: Thank you, Dr. Peplau. Now I would like to present to you Dr. Eileen Jacobi, Executive Director of the American Nurses' Association.

DR. JACOBI: It is certainly my pleasure to be here and to participate in this conference. I have enjoyed working with the Council for the last four years and look forward to working with them even more closely in the future. I want to wish you every success in this very timely program.

MISS PEEPLES: Thank you, Dr. Jacobi. And now I will turn the meeting over to Mrs. Mildred Frederickson, Vice Chairman of the Council, who will introduce the guest speakers.

MRS. FREDERICKSON: The Council of State Boards of Nursing has planned this Educational Conference so that all of us may be able to focus on the issues of licensure and health personnel credentialing.

The need for certain improvements in the present system of health manpower, licensure, certification and accreditation seems to be well documented. There is a great deal of ferment in this country today concerning health manpower credentialing matters. All of you are well aware of this. In almost every state there is interest, not only on the part of those who are vitally concerned and influenced by health manpower credentialing matters, but also by many other groups of people.

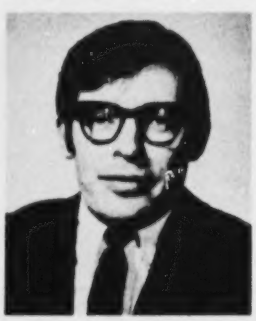
Meaningful solutions must be found not only to remedy our present problems, but also to be responsive to future changes in the health delivery system.

We have with us this morning two individuals who have been very involved in studies related directly to the issues and problems before us.

Our first speaker is Mr. Ronald Wylie. Mr. Wylie's work has appeared in a number of publications. He holds an LL.B. degree from the University of Michigan Law School and is a member of the American Bar Association. At the time the HEW Report on Licensure and Related Health Personnel Credentialing was made, Mr. Wylie was the director of the political and legal analysis branch of HEW. He currently is director of Human Resources of the Appalachian Regional Commission.

Our second speaker is Dr. William K. Selden. Dr. Selden was a participant in the State Boards of Nursing Conference on Accreditation in 1969. He has been the Executive Director of the National Commission on Accrediting. At present, he is Director of the Study of Accreditation of Selected Health Educational Programs.

THE HEW SECRETARY'S REPORT ON LICENSURE: A SUMMARY



Ronald Wylie, LL.B.
Director of Human Resources
Appalachian Regional Commission

I thank you for the opportunity of summarizing the Department of Health, Education and Welfare Secretary's Report on Licensure which went to the Congress in August, 1971.

The Report has truly been a joint effort and certainly it would be presumptuous on my part not to make it clear that what I am expressing here today are the views as I see them.

Fairness demands that I mention that I am not here as a representative of the Department of Health, Education and Welfare. I have accepted responsibilities with the Appalachian Regional Commission and, although I have been called on and am in continuing contact with the

Department in these particular matters, I cannot speak with current insights into the various DHEW activities, nor should my comments be construed as Departmental commitments.

It is not my intention to speak exclusively of licensure problems affecting only nursing. Your schedule includes a number of speakers much more qualified than I am to lead a public discussion on the technical credentialing questions that your leadership must face. Nor can I promise assurances for all of your major concerns. To attempt to do so might be, first of all, inappropriate as cheap politics and, secondly, unperceptive of a variety of pressures that cut through a complex field in which reasonable men and women can differ.

As Assistant Secretary DuVal recently stated, "There is probably no single issue faced by DHEW that has more complicated sub-issues than this particular one."

Let me momentarily comment on Departmental activity in this field prior to the Report. Former Secretary Robert Finch had a special interest in the field of licensure and credentialing of health manpower. Shortly after he entered the Department of Health, Education and Welfare, he initiated meetings with a group of private foundations to explore what he called the "gutsy" health care issues that the foundations and DHEW could most meaningfully attack in some kind of coordinated fashion — licensure was on that agenda.

In 1969, you may recall that in their report to President Nixon, "The Health of the Health-Care System," Secretary Finch and Assistant Secretary Egeberg specifically mentioned the matter of licensure and asked that each governor and each state legislature review the statutes and regulations in their states with an eye toward making them more responsive to contemporary needs. Shortly thereafter, Assistant Secretary Egeberg asked for a three-month staff study on the subject. This study was completed with emphasis on physician extender personnel. It was about that time that pending legislation, ultimately known as the Health Training Improvement Act of 1970, had the provision inserted calling for the Secretary of DHEW to prepare and submit to the Congress "a report identifying the major qualifications for practice or employment of health personnel." The Secretary was to include his specific recommendations for steps to be taken toward the solution of the problem so identified in such a report.

The DHEW Secretary's *Report on Licensure and Related Health Personnel Credentialing* is a result of this legislative mandate by the Congress. In welcoming this responsibility, the Department moved forward on the following assumptions:

1) That credentialing matters are basically state matters and that while there is a very definite role for the Department, as indicated in the Report, the Department was not taking the position that federal pre-emption was generally appropriate.

2) That a statistics-oriented, category-by-category approach would not satisfy the Congressional mandate, but instead the Report should attempt to survey present practices and raise what appear to be their serious shortcomings. Most of the health professions have common credentialing problems.

3) That medical specialty certification, an increasingly important subject, was not thought to be appropriately included in this Report.

4) That "hard data" was very difficult to come by, particularly in the approximately thirty categories surveyed, but that we should make every effort to get whatever was available, and that a good amount of post-Report efforts should be invested in developing data. Parenthetically, there undoubtedly is considerably more useful credentialing data in the field of nursing than in several others.

5) That this subject is no longer a technical one, only for the narrow specialists, but is really pivotal to public policy in the health field. Having said that, however, we should realize that credentialing is only one factor among many in assuring a better utilization of our scarce health manpower resources.

6) That the challenge in this field, as it is in other fields in the area, is to recognize the transitional nature of health care in the United States today and, therefore, to avoid proposals that would lock us into patterns which ten years from now would not find us any better off; in fact, might find us worse off. At the same time, we cannot use the thinking that the health care field is in a transition as an excuse to avoid specificity with regard to recommendations.

7) That of all the considerations which must be taken into account in formulating sound public policy in licensure, none equals the importance of the public safety aspects — patient considerations are absolutely paramount.

8) That economic realities for persons earning their livelihood in the health professions are tied to matters of licensure and certification and must not be overlooked or lightly dismissed by policy-makers.

9) That the authors of the Report could not be arrogant enough to believe that they would have all the quick answers, but instead realize that they had an opportunity to construct a vehicle for meaningful change by proposing steps that orchestrate appropriately the state-federal and the public-private roles. I think the summary will indicate the emphasis which we placed on those kinds of partnerships.

In preparation of the Report, we had working liaison with over fifty people in different agencies within DHEW and elsewhere in the federal government, and there were some seventy associations like yours represented at the May working conference. We asked for written comments at that conference and I can assure you that they were gone over word by word. There was a serious effort to utilize the input from the conference. Thus, we were able to benefit from a good cross-section of thinking from the private as well as from the federal and state levels.

We have been generally pleased with the reception accorded the Report. Because of the ferment that has already been mentioned in this field, DHEW has received a large number of requests for the Report. Perhaps, the most meaningful comment was made by the writer of the "Washington Newsletter" in the October 4, 1971, issue of *Modern Medicine* where he indicated that the Report is still another piece of evidence that "DHEW is trying to deal rather specifically with some of the country's health manpower problems" and that early reaction among health professions who had seen the Report was only praise.

More important, however, than all these nice words is concrete accomplishment of the type that DHEW's Social and Rehabilitation Service recently initiated in attempting

to strengthen the hands of states in raising and enforcing nursing home standards. As many of you are aware, there are new regulations tied to the Medicaid program (under which nursing home administrators are licensed) which prohibit nursing home administrator licensing boards from having a majority of their members made up of representatives of nursing homes. Nor can members of single professions, such as physicians or nurses, constitute a majority on these boards. Such action is consistent with the Secretary's Licensure Report.

It was not by accident that the format of the Recommendations Chapter had four Departmental Actions listed first. We have always subscribed to the idea that in terms of reform, your own backyard first, the world next! Assistant Secretary DuVal commented to me that the recent presidential health message, the far-ranging health manpower legislation recently enacted and the Report really add up to an "irreducible commitment" by DHEW to stimulate progress in the regulation of manpower serving the nation's health needs.

The four Departmental Actions spelled out in the Report are as follows:

1) To establish an expanded information base and additional consulting capacity.

2) To review health services and training programs.

3) To undertake additional accreditation studies which may be needed in the health field.

4) To make a determination of the feasibility of a national health professions certification system.

And, lastly, I should mention, in connection with the moratorium call, that the Secretary indicated that a one-year interim report covering the last twelve months of credentialing activity would be done by DHEW.

Time will permit only an overview of intentions inherent in these proposals and their implementation status.

EXPANDED INFORMATION BASE

A number of organizations have shared our frustrations with the general lack of hard data available on a current and systematic basis. You are acquainted, of course, with Maryland Pennell's 1968 updated compilation, *State Licensing of Health Occupations*, which was done with the help of the Council of State Governments and the National Center for Health Statistics of the Public Health Service. This compilation has been the "classic work" in this field and meetings have been held with the expectation that it might again be updated.

But more insights are needed with regard to manpower regulatory schemes as social institutions; studies of decision-making, expected roles, resources available and those utilized; and the interrelations between organizations. Such an effort can best be accomplished within the real worlds of health service needs and overall manpower strategies. For these reasons we expect the federal-state-local health data systems now being assembled and assessed by the National Center for Health Services Research and Development to be a meaningful tool for refined decision-making on matters that are related to a "public interest" approach to credentialing. The National Center has also recently established, on a limited basis, a service for systematically following bills introduced in all of the state legislatures on the subjects addressed in the Report.

I should also mention that the Division of Manpower Intelligence of the Bureau of Health Manpower Education is making a critical effort to develop authoritative data bases from which to project supply and requirements. I assume that your professional association is participating in this program, as many are, in an effort to improve the collection of relevant data and to enhance the comparability of data among the professions. Obviously, data related to licensure, certification and accreditation should be included in these undertakings.

Such information gathering is justifiable only if it is the basis for action. With the kinds of information needed in hand, DHEW could, as it has not always been able to do in the past, respond to state requests for consulting assistance in evaluating health manpower regulatory schemes and for the drafting of progressive state legislation covering health manpower.

REVIEW OF HEALTH SERVICES

The second Departmental Action — review of health services and training programs for consistency with policy objectives in personnel standards, job opportunities and career development — is in line with Secretary Richardson's vigorous efforts to fashion an integrated, responsive Department. My understanding is that his Executive Secretariat has been given increased responsibility for policy development monitoring among DHEW's approximately 270 different programs. A recent Congressional Report, "Health Manpower Programs in the Federal Establishment," indicated over 140 health manpower programs in thirteen departments and agencies. The Health Manpower Planning Group, composed of representatives of the Health Service and Mental Health Administration and the Bureau of Health Manpower Education of the National Institute of Health, has been established to interrelate the planning of the various components of health manpower: education, distribution and utilization. In seeking to prepare a guidebook on health manpower planning, this Group will seek to illuminate issues such as productivity, task analysis, licensure, certification, equivalency and proficiency testing.

In addition, what is needed is an ongoing analysis to assure that health delivery systems funded by the federal government are not inconsistent with policy pronouncements, perhaps, even at the level of a presidential message. As an example, I recently saw correspondence wherein a DHEW grantee on a project to develop nurse practitioner models was questioning the failure of Medicare and Medicaid to reimburse nurse practitioners for services of the kind and under the circumstances that the grant was given originally to encourage. This kind of a situation must be given attention wherever standards exist in different programs. There also must be continuing assurance that new programs do not fail to provide a vehicle for the implementation of policy objectives that are thought to be highly desirable.

ACCREDITATION

Inasmuch as my friend, Bill Selden, is our next speaker and is obviously an expert in the field of accreditation, I do not intend to take time commenting at length on the accreditation action which was the third Departmental Action, the responsibility of which was assigned to the

United States Commissioner of Education. We, of course, were focusing on educational programs for the health professions as was Dr. Selden's project, the Study of Accreditation of Selected Health Educational Programs. We have always felt that it was a most constructive undertaking for the sponsoring organizations of his study to get together on this project. We viewed our recommendation in the accreditation field as a supplemental, not a substitute, project which would deal more with the regulatory structures of accreditation and the appropriate role for the federal government.

The Office of Education has been involved with the Brookings Institution in an effort to sharpen the issues and develop alternative methods of investigation for any additional accreditation work undertaken by the Office of Education. I have been personally concerned that any additional launchings be held back until a full analysis could be completed of the final report on his project. The Commissioner of Education has assured that the timing and content of our projected study, the one we call for in our Report, will depend, in part, on the final recommendations of the accreditation study. Public discussions of accreditation have also had the recent input of the Newman Report which got a fair amount of publicity and which dealt with higher education in several aspects, including credentialing. I would expect that the Office of Education efforts will take the Newman Report into account, as well.

CERTIFICATION

The last DHEW Action calls for a determination of the feasibility of national health professions certification. The Assistant Secretary of DHEW is responsible for the development of this part in terms of the follow-through of the Report. The feasibility study has already been delegated to and undertaken by the Bureau of Health Manpower Education.

There are those, of course, who have advocated that the time has come for enacting "federal licensure" for all categories of presently licensed health personnel and, perhaps, even for some not now licensed. A good deal of the discussion regarding "supersession of state law," where it may be found to be inconsistent with federal enactment, has centered around approaches to the regulation of HMO's. This is not the place for a long discussion on the substantial constitutional questions so raised. Suffice it to say, and against the urgings of some, we do not foresee the broad replacement of state boards. This is not to say that, sometime in the future, some form of national standards for licensure in the health professions may not be desirable, but at this time we feel that several current activities will have a much more constructive impact than federal licensure per se.

One last point — some people have read the Departmental Action calling for a "report exploring the feasibility of establishing a national system of certification for those categories of health personnel for which such certification would be appropriate" as advocating national licensure. As I tried to point out, that was and is not the intent. The study will deal with a national system to be distinguished from a federal system, will deal primarily with allied health occupations, will deal with the issues that are relevant in attempting to improve certifying practices (testing, financing, et cetera), and will provide for a major input by the professional organization. We have given a good bit of attention to that latter point. It is not merely bureaucratic assurances when I say that we are seriously interested in seeing that this point is accomplished.

In summary, we look forward to a state and federal fusion of interests and action. We must now make sure we can answer positively the question that I think one person put recently in a very clever way: Does such a fusion lead to infusion, intrusion or confusion?

The following recommendations were made and we urge groups such as yours, along with others, and the states to give them every consideration:

1) A two-year moratorium.

2) Expansion of the functional scope of health practice acts and expansion of broader delegational authority.

3) Adoption and full utilization of national examinations. You certainly have the advantage over several other groups in that regard. There should be support for the development of additional exams as soon as possible, in order to increase uniformity.

4) Development of meaningful equivalency and proficiency exams should continue.

5) State licensing boards are urged to take, with the active support of the professional associations, new steps that will strengthen the boards and will allow them to play an active role in maintaining high quality health services.

6) Professional organizations and states are urged to incorporate a specific requirement for the assurance of a continued level of practitioners' competence as one condition is a recredentialing process.

7) Institutional licensure — to include the regulation of health personnel beyond the traditional facility licensure — should be subjected to demonstration projects as soon as practicable.

All of you, obviously, can read the Report. You can study the details and make your own conclusions. As a concurrent major work sponsored by the Department of Labor, I would recommend Dr. Benjamin Shimberg's recently completed three-year study on occupational licensure which will soon be available from the Educational Testing Service. This covers not only the health fields, but the whole broad spectrum of occupations which are presently licensed. In my opinion, Dr. Shimberg has made a real contribution to the subject of licensure. I also would bring to your attention the publication put out in November, 1971, by the National Health Council which gives a summary of activities in licensure, accreditation and certification reported by selected national organizations in the health field.

There are a couple of matters that I have been asked about that I would like to mention briefly.

CALL FOR MORATORIUM

First, the Secretary's call for a moratorium. This was not an original step since several associations, including the ANA, had backed this proposal. It was, however, considered judgment that the Secretary's endorsement of the concept would be very helpful in achieving the desired result. As a practical matter, you will note that the Secretary did not advocate an open-ended "freeze" on licensing; instead it was for two years with an interim report at the end of the first year to ascertain the effectiveness of

the moratorium call. Making the moratorium nonopen-ended should dramatize the fact that it was not anticipated that the moratorium was to be a mere passive "holding action," but instead should be used in a constructive way as a period in which concrete action on other recommendations could be forthcoming.

NATIONAL TASK FORCE

This leads me to the next point. A number of leading persons have called for the establishment of a national task force to recommend means of improving licensure practices. In some cases, considerable time and effort has already been expended in attempting to move towards this objective. This leadership, both in the case of persons and organizations, deserves commendation. For it is clearly the case that several aspects of licensure need more study and the nature of the issues suggests that whatever is done to change or improve the system must be done through the collaborative efforts of many vested interest groups.

The Report, as you will note, did not mention a national task force. At the time the Report was to be made public, delicate negotiations were in process between major organizations with the hopes of creating a representative sponsorship that would enjoy genuine public confidence. To be expressly negative on the task force would have been, in our opinion, unfair to those who were making such good faith efforts and it may have contributed to the premature death of a vehicle that could and should be used. On the other hand, my personal feeling is that yet another "study committee" may not be needed. To go that route would give those opposed to action a "socially acceptable" justification for obstructing any changes in the status quo for at least the period for which the committee was authorized and the proposal I saw was for a period of at least two years. More could be achieved during that time, in our thinking, by pushing for concurrent activities on a number of fronts. Little enthusiasm for the national task force idea has come to my attention of late.

MODEL LAWS

Another aspect of this field is the potential of so-called "model laws." The provision of the Health Training Improvement Act which calls for the Secretary's Report initially asked for the establishment of a "model code" for the allied health professions, but that, obviously, was dropped. The Secretary had a small Departmental task force look at the feasibility of a model law for physicians' assistants. A bill, as you may be aware, has been introduced in the Senate which would give the Secretary the responsibility for promulgating such a model law to be used by the states. As far as I know, there has been no action on the proposal. At the suggestion of two governors, the National Conference of Commissioners on Uniform State Laws has tentatively placed upon its agenda the development of a model or uniform law and an intensive study of this subject, as I understand it, is to be undertaken later this year.

The model law approach needs more attention and I would like to see a group of experts be convened to work exclusively on this subject. Again my own feeling is that there are too many different considerations which exist across occupational lines to expect any one statute to do the job without major modifications to the system as we now know it. Furthermore, one can easily overstate the value of such a model statute. It takes time for a meaningful number of states to enact them, especially where economic interests are directly involved and they are usually not uniformly enacted or construed within the various states.

INSTITUTIONAL LICENSURE

I have been asked about our expectations on the subject of institutional licensure. The Report called for the initiation of "real life" demonstration projects of what is now only a concept—the concept being that of the state licensing a health services institution, including its health personnel, rather than the individual practitioner working in the institution. We said that institutional licensure should not, at this time, be overstated as a panacea — it has its drawbacks and, for the foreseeable future, it appears that it could, at best, be a supplement, and not a substitute, for licensure procedures as we now know them. There is no doubt that it would be a force which could change, to some degree, the sociology of the health professions and it will require that institutions undertake certain internal steps that most have not done nor, in many cases, have little desire to do.

The Illinois Hospital Association has applied for a demonstration grant, as many of you know, in conjunction with several other Illinois organizations. They anticipate using the network of institutions around the state which are affiliated with their medical schools and a number of different kinds of institutions.

My understanding is that the DHEW would welcome discussion of additional applications representing other settings in different regions of the country.

I might add just a personal observation. Although some reasonable people feel that institutional licensure poses a threat to the individual nurse, my experience is that at least two of the most knowledgeable people in the licensure field, people who have also been closest in their work to the nursing profession, are among those advocating at least a trial for an institutional approach. I think maybe it is appropriate for me to just say that we should not go into it with preconceptions. It may well turn out that it is literally a "bag of worms." It seems to me that at this point we could justify the public investment in demonstration projects to learn more specifics of its possible benefits as well as its deficiencies.

STATE EXAMINING BOARDS

Lastly, those of us gathered here today must be concerned about the questions raised by the Shimberg study which I have already referred to:

1) At a time when the public is increasingly impatient with the professions, how can the boards help to rescue the image of professionalism from that of mere self-serving, vested interests?

2) How can boards move on their own initiative without awaiting legislative action, but pushing it where necessary to improve testing procedures, make testing locations more convenient, assist with language problems, deal constructively with candidates who fail, improve record keeping, undertake necessary research, sharpen board ethics, make board operations more efficient and generally improve communications in a number of

directions? These are very practical kinds of things that many of you in this room are concerned with and have to live with on a daily basis.

3) How can we best achieve the revisions in the practice acts to recognize the achievements of professional education and then possibly accept for licensure bona fide graduates of accredited schools?

4) How should boards best respond to their increased responsibility for assuring that practitioners are maintained at a proficiency level that results in consistent quality care?

5) More specifically, how can they function to discharge that phase of their responsibility which cannot be assigned to any other agency; namely, the problems of illegal and unethical practice?

6) What kind and how much direct assistance should be provided to boards so that they will have the staff and other resources required to do the above tasks over an extended period of time?

Time does not permit me to go into the unfinished business that we have in terms of foreign graduates, continuing education and career mobility.

INTEREST IN CREDENTIALING

Congressional interest in credentialing is growing as more members see that it is a critical element in providing for the national needs in health. As examples, Secretary Richardson was questioned very directly regarding Departmental activities and plans on licensure during his appearance this year before the House Appropriations Subcommittee. In offering his National Institute of Health Care Delivery Bill, Senator Beall of Maryland outlined, as one of the major functions of the proposed Institute, the areas of delegation of duties, continuing education and manpower credentialing. Perhaps, even more important, the State Legislatures, in many instances, are pushing forward in this arena. Tennessee has, I understand, established a Division of Paramedical Licensing, Illinois created a Health Care Licensure Commission and a number of states are showing interest in establishing state groups to grapple exclusively with these problems.

Several other efforts deserve at least a quick mention. You are all aware that the Carnegie Report gave prominent attention to licensure problems and that the National Health Council intends to follow the national scene carefully. The National Commission on Accrediting continues to give leadership in its area of expertise, both in connection with Bill Selden's study and also by virtue of involvement in other activities. The newly established National Institute of Medicine, affiliated with the National Academy of Sciences, has as its first major undertaking, I understand, policy analysis in the health manpower field. I am sure that is going to touch on the issues of credentialing very directly.

With local RMP support and additional federal funding anticipated, a consortium of schools, hospitals and other educational institutions in New Haven have organized an allied health institute to encourage young persons to enter a health career and then move up the professional ladder. Extending from high school through Yale's Medical School, this work-study program presently has two hundred youths studying pre-nursing and various health technology courses. They are discussing a nursing program that would allow LPN's to build on their educational background if they sought to be registered nurses.

In an area which is gaining more attention from professional nurses, the Secretary's Medical Malpractice Commission is expected to make recommendations this fall which will relate to the qualifications of personnel, professional liability and insurance aspects. As you know, professional associations like the Oregon Medical Society are taking solid steps, to the point of the expulsion of members, to see that requirements on such matters as continuing education are met by all of its members. Even the American Bar Association is in the act. Their National Clearinghouse on Offender Employment Restrictions is initiating a state-by-state study of laws which prohibit or limit job opportunities for ex-offenders. The study is to be completed by the end of May and is to include procedures of state licensing boards.

The federal government will clearly have a continuing interest in all aspects of credentialing beyond what it has had in the past. What I am really saying in that comment is that it will be joining those already at work on these problems, as indicated above.

The nursing profession certainly has been at work. Your "Principles of Legislation Relating to the Practice of Nursing" has been of practical help. Joint professional statements have been really the epitome of professional responsibility in attempting to bring about a more meaningful certainty in otherwise unclear areas of professional interface. In the preparation of the Report, we were pleased to note the potential of statutes like the one in Idaho which provides for joint regulations under the nursing and medical practice acts concerning extended roles for the nurse. We are expecting a great deal of good to come from your recently established National Joint Practice Commission with the AMA.

EXTENDED ROLES FOR NURSES

The conclusions of the Secretary's Committee to Study Extended Roles for Nurses is evidence that a committee with broad representation of nurses, educators, administrators and physicians can come up with progressive recommendations that merit serious examination.

Nurses represent the single largest pool of professional health personnel available to address the problems of modern medicine. There exists now really a unique opportunity for nurses to step briskly into the void that is now being created or has been created by a scarcity of physician's services, a scarcity both in numbers and also in the kinds of services available because of the impact of medical specialization.

Let us heed one of the guiding principles of this Administration's health strategies: we must build on the very real strength now inherent in the American health enterprise while we work with vigor and persistence to overcome its weaknesses. Let us channel our energies into the most meaningful issues. Perhaps, we should, for instance, be hearing a little more about "patient assistants" rather than "physician assistants"!

The encouraging finding of the Extended Roles Committee was that there are no major legal barriers related to the extended and anticipated functions. The barriers are more traditional than legal.

The American people are clearly demanding that all of us get on with the business of eliminating all barriers, both traditional and legal, to making quality health care available to all individuals within this great country. That

must be the clear purpose of your meetings here and, on that basis, I have been pleased to be with you.

DISCUSSION

MARJORIE SCHLOTTERBECK (Idaho): I wonder if you would care to share with us some of your personal beliefs on what may happen in the next five years?

MR. WYLIE: In terms of the next five years, I would think that 1972 might well be a major year in determining what is going to happen in the next five years.

We do have, as we are all aware, a presidential election. I do not think it is inappropriate to mention that.

In response to your question, I just really do not know. I know it is a fact that the Department at this time has taken the approach that I have mentioned here.

I recall at one presentation Dr. Endicott, who has been in the health establishment in Washington for many years, saying that all of this is fine, but the fact is we are discussing this whole issue in the context of the clock running with regard to national health insurance.

SADIE READING (Florida): In speaking about licensure or credentialing, do you use these two terms synonomously or do you see these as licensing first and then additional credentialing?

MR. WYLIE: You recall that the mandate of the Congressional legislation spoke to licensure specifically, but also broadly to any other aspects that dealt directly with the employability or the utilization of the various categories.

We have used the word credentialing to encompass licensure as well as the certification of the professional groups. The latter is particularly important in those categories where no licensure now exists and where, if you permit me a minute to editorialize, we thought it would be constructive if it did not exist in the foreseeable future. We used "credentialing" also to cover the issue of accrediting. However, we did not use it to indicate that licensure is synonomous with certification.

GENEVIEVE JONES (Georgia): Is health planning fragmented as it seems to be? Is there any one group or one person that is really doing it? Do you see planning for nursing, planning for medicine and planning for health care as interrelated or parts of the whole?

Also, in mentioning the nursing home board, you said that it was not to be composed of more doctors and nurses than lay people. I wonder if nurses are really on these boards in any degree of quantity throughout the country? And, in the area of hospital boards and hospital authorities, has there been any study done to see if there are any nurses serving on these boards?

MR. WYLIE: To answer your questions concerning health planning, I think that it is pretty fragmented. I have tried to indicate exactly what the status is in terms of the number of programs — 270 programs in DHEW and 140 different places in 13 departments and agencies are dealing directly with health manpower. It is no secret that this is a real problem, but there are some very directed and continuing efforts to try to pull these programs together as far as the Department is concerned.

Another major element in this area is the comprehensive health planning agencies throughout the country. As you know, probably every state agency has had some kind of survey, data collection and compilation efforts in regard to health manpower. Serious questions have been raised in Washington by the Congress as to just how effective all this "comprehensive health planning" has been. There seems to be agreement that it will need to be strengthened. I think that the appropriation request for comprehensive health planning has been increased very substantially this year. DHEW Secretary Richardson has indicated that he expects there will be regional comprehensive health agencies blanketing the country in the foreseeable future.

As to the second part of your question dealing with the boards of nursing homes, I cannot give you statistics. The regulation that I referred to was simple that no one profession would hold a majority on the nursing home boards. I do not know how that would directly affect nurses. I think, unfortunately, that nurses have not, generally, served on the hospital boards. We have noticed an increased interest in getting physicians on these boards in a little different role than physicians are used to playing.

MRS. JONES: At this time, I know of only one nurse that has ever served on a hospital authority. We have questioned whether this might not have been a first and if anybody does know of another instance, we would like to be apprised of it.

IRA DEAN LANE (South Carolina): I have to say we do have a nurse who is a member of the board of hospitals. She is the president of the South Carolina Nurses' Association.

REBECCA CULPEPPER (Tennessee): Speaking in relation to the question of nurses serving on a hospital authority, Nashville, Tennessee, had a charter revision seven or nine years ago and became a metropolitan government. At that time there was a creation of a hospital board. The local district was very active in seeing that a registered nurse was included on that board. They have also had nurse representation on the hospital board of Nashville, Davidson County, since the inception of the metropolitan government.

FAY WILSON (California): Please expand on the statement regarding the demonstration projects on institutional credentialing. I would like to know how this will be developed and who would assume the responsibility for such a project.

MR. WYLIE: The Report's recommendation simply acknowledged the fact that institutional licensure was 1) a concept; 2) being much talked about; and 3) in the minds of people who had been working in that field, and were considerably more expert than some of the rest of us. It was felt to have a good potential.

You will note, however, that the recommendation did not endorse institutional licensure. It said, in effect, that the Department should, in delivering this Report, be willing to allocate some money in the immediate future to groups that would undertake to test the conceptualization in the real world.

Now, as you know, Nathan Hershey and others have been talking about this and the Ameriplan came out with the idea in general form. It has been discussed in several contexts. The overall scheme is that the institutions would set up position descriptions within the institutions or organizational setting. These descriptions would then be approved by a state agency. There would be a description of the kinds of qualifications, which might be formal or not so formal needed by the person filling the position. Then the state agency would approve the candidates who were submitted by the organization for those particular

positions.

There are a lot of questions to this whole approach. Does this kind of approach really get us any place we have not been? In the area of career mobility — if somebody were working in a particular organization in a more narrowly defined position description, he might have a great future in that organization, but, perhaps, not elsewhere. You would also get the argument of who should be included, both "dependent" and "independent" practitioners? These are the kinds of questions that we would hope somebody, with the funding support of the Department, would try to answer concerning this concept.

Who should undertake this? Groups that are either chartered specifically for that purpose with representation from the various categories or, like the Illinois Hospital Association, with broad representation from the various health professions in Illinois. I think that kind of an organization is the kind which could best undertake this project.

We do not think that any one or two demonstrations per se are enough to test the concept of institutional licensure. It is my understanding that DHEW would be happy to entertain additional applications for various regions of the country.

DR. PEPLAU: Mr. Wylie, you said that institutional licensure would change the sociology of the professions. It seems to me that any major change in licensure or credentialing is likely to do this. Furthermore, how the federal government defines requirements and supply (which you said they would, based on the information gathered) and how the federal government will then allocate funds to make that supply available also has considerable impact on the sociology of a profession. I think we are going through a period of anti-professionalism in this country. This is certainly indicated in the tremendous proliferation of health occupations and health technicians which you referred to. Should there not be some formulation of philosophy about the role of professions at this juncture in society? We have thought for a long time that a major aspect of regulation was self-regulation within the profession with some extension of the regulation to the government in the public interest, but the assumption being that most of the regulation occurrs within the profession. It seems to me that the situation is changing. I would like you to address yourself to the matter of philosophy or the sociology of the professions, as you put it.

MR. WYLIE: I think you are quite right. There is a violent anti-professionalism that pervades a lot of the thinking in some quarters. It can either be channeled in a constructive way or it can be a destructive force in connection with values that have made a contribution to this country. The whole idea of professionalism, as you pointed out, really needs a lot more attention as a major national issue than we are giving it.

To come specifically to the philosophy that guided us in this particular Report, it was amazing how many people there were who suggested that we quite drastically change this credentialing business and relationships.

I mentioned federal pre-emption. I do not think people had very much appreciation for what that meant in hard legal terms and its political feasibility. There were comments like "Why do you talk about the continuation of boards? They have not done anything, so we might as well wipe them out and get on with a system that will work." We did not think that the people who were saying that could offer hard data to support their case.

Our approach indicates a concern for going forward, but deliberatively responding to constructive suggestions.

I appreciate your bringing this up because I hope I gave sufficient emphasis to another factor that I think is terribly important: It is easy for all of us to go anywhere — in my case to Washington — and forget sometimes about the realities of earning a living. I do not think this is a subject that we need to apologize for addressing ourselves to. This whole business of credentialing is tied up very directly for a lot of people to their concerns for earning a living. I do not think that we should easily or flippantly tamper with that until we really understand what the ramifications are going to be.

I would hope that the National Institute of Medicine for instance, would do just exactly what you are talking to in terms of addressing itself to the health professions.

I appreciate your raising the issue.

A STUDY OF ACCREDITATION OF SELECTED HEALTH EDUCATIONAL PROGRAMS: A REPORT

William K. Selden, Litt.D, LL.B
Director
SASHEP

Let me report today on the Study of Accreditation of Selected Health Educational Programs, more familiarly known as SASHEP. This is a study with which some of you may not be familiar. Financed by a grant from the Commonwealth Fund and co-sponsored by the American Medical Association, the Association of Schools of Allied Health Professions and the National Commission on Accrediting, it was charged to look at the accreditation conducted for selected health educational programs. The fifteen selected programs included such fields as radiologic technology, medical laboratory assistants, medical record librarians, et cetera. The study has been conducted within the context of all the health professions.

We are indebted to the American Nurses' Association for the cooperation which its officers and staff have shown in assisting in the program. Also, we especially are indebted to the National League for Nursing which provided voluminous information at our request.

We have issued two sets of staff working papers, one of which I wish to refer to in more detail. As long as the supply lasts these papers may be obtained for one dollar each by writing to SASHEP, Room 760, One DuPont

Circle, N.W., Washington, D.C. 20036.

The first set of working papers included the following topics: *Historical Introduction to Accreditation of Health Educational Programs, Structure of Accreditation, Financing Accreditation, Research in Accreditation, Expansion of Accreditation* and a commissioned paper entitled, *Accreditation of Postsecondary Education: Problems in Organization*. This set was issued in October, 1971.

The second set of working papers was published in February, 1972 and contains the following titles: *Dilemmas of Accreditation of Health Educational Programs, An Approach to Accreditation of Allied Health Education, The Relationship of Accreditation to Voluntary Certification and State Licensure* (to which I will speak this morning) and a commissioned paper on *The Law's View of Professional Power: Courts and the Health Professional Associations*, which was prepared by a professor of law at the Catholic University of America and which many lawyers are finding extremely helpful.

There are four primary processes conducted under the broad term of credentialing. SASHEP has defined these as follows:

Accreditation is the process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards. It shall apply only to institutions and their programs of study or their services.

Certification is the process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

Licensure is the process by which an agency of government grants permission to persons meeting predetermined qualifications to engage in a given occupation and/or use a particular title or grants permission to institutions to perform specified functions.

Registration is the process by which qualified individuals are listed on an official roster maintained by a governmental or nongovernmental agency.

The third and final report (the Commission Report), which is now being published, contains three sections. The first is a summary of the main issues identified by our staff working papers. The second section is a statement of basic policies for accreditation. Even though we were not charged in this study to look at all postsecondary accreditation, it was necessary for us to prepare a document that identified basic policies, because none to date exists. We have endeavored in this section to identify broad issues related to accreditation and to present impersonal philosophical recommendations. The third section contains specific conclusions and recommendations as they relate to the accreditation of the fifteen selected health educational programs. The accreditation of these fifteen selected fields is done collaboratively by the respective professional organizations in conjunction with AMA which, through its House of Delegates, has final authority on the essentials or standards and, through the Council on Medical Education, has final authority for deciding which programs will be accredited.

RECOMMENDATIONS

The first recommendation is to the effect that the three co-sponsors of SASHEP, namely, the AMA, the Association of Schools of Allied Health Professions and the National Commission on Accrediting, jointly sponsor one or more meetings to discuss and implement the concepts contained in this report.

The second recommendation calls for the creation of a new structure, the proposed name of which is the Council on Accreditation of Education for Allied Health Professions. This recommendation raises a fundamental issue which has been historically of sensitive concern to the profession of nursing. We are proposing the creation of a new organization which would not be subservient to the American Medical Association. There would definitely be participation in it by physicians and other professional groups, including representation from each of the health professions subject to accreditation. There would also be representation of the public proposed or appointed by the Education Commission of the states. We propose representation from potential employers identified by the National Health Council and the American Hospital Association. We also make provision, as associate members, for representation of the nursing profession.

The third recommendation concerns certain philosophical questions in accreditation which I will not take the time to explain, except to say that if we proceed on the basis that the profession should have some say as to who is admitted to the profession and who is licensed to practice in the profession, how does one resolve the contention that these operations involve some issues of broader social import than can actually and adequately be resolved by members of the professions alone? It is my further contention that when it comes to technical-professional matters, in contrast to those that are of broad social import, the members of the profession directly concerned are the most competent to make such decisions. However, when it comes to broad social issues the members of the profession should not have sole authority.

One of the great fears of many members of the profession of nursing was evinced at a meeting which I attended in Dallas where the associate degree programs held their session. There was a very able person who accused me of talking about "control." I had not used the word control, but it was an example of her interpretation. I had said there had to be cooperation, collaboration and coordination among the health professions, including medicine and nursing. But she showed her emotional hang-up by then concluding with the statement: "I consider control of the nursing profession to exist whenever one physician sits on a board concerned with nursing."

I am not trying to ridicule the point of view. I am simply pointing out that this is a self-protectionist attitude of which the health professions collaboratively must disabuse themselves. This includes medicine. It is my contention that there needs to be cooperation among the groups and that medicine should have representatives from other health professions involved in helping to develop suggestions for the future of medicine, just as medicine should be involved in helping to plan for the future of nursing.

RELATIONSHIP OF ACCREDITATION TO CERTIFICATION AND LICENSURE

With this philosophical background, may I now call your attention to the paper, *The Relationship of Accreditation to Voluntary Certification and State Licensure*, which is contained in the second part of the SASHEP staff

working papers. It was prepared by Karen L. Grimm, a member of our staff during this study. She has now joined the staff of the National Institute of Medicine. The paper states:

> Initiated by different groups, at different points in time, in response to diverse social and economic conditions, the processes of accreditation, certification and licensure were originally conceived as independent procedures geared to distinct goals and objectives. Today, in the hands of a wide variety of health professions, accreditation, certification and licensure are bound together by a complex array of interlocking relationships, which through time have forged all three processes into one comprehensive health-manpower credentialing system.
>
> Accompanying this structural evolution was a revolution in expectations. Once conceived with limited and somewhat prosaic objectives in mind, the companion processes of accreditation, certification and licensure are now collectively called upon by society to assume the weighty responsibility of identifying competent personnel to staff its health care system. In the course of this metamorphosis, the patterns of control, procedures, and mechanics of accreditation, certification, and licensure have changed little since their inceptions in the nineteenth and early twentieth centuries. However, the social milieu in which they must operate, the purposes they are called upon to serve, and the issues they are expected to address have undergone traumatic transformation.

What we endeavor to point out in this paper is that there have not been corresponding changes in the operations of these procedures and their relationship to each other commensurate with the changes in social issues and philosophical attitudes. This paper then identifies the relationship of accreditation to certification, which I will not present to you because it is not the subject of this meeting. However, let me continue by discussing the relationships of accreditation and licensure.

> Just as early state legislatures delegated the primary responsibility for formulating and enforcing medical licensing laws to the medical profession, so do states continue to rely upon other health professions for both formulating and enforcing their own licensing statutes. Model statutes are usually drawn up by the national health professional organizations; and state associations, often founded for the express purpose of securing passage of licensure laws, run the proposed bills through the legislative mill. State licensing boards are usually selected from lists provided by state health professional associations, and professionally drafted codes of ethics are many times incorporated into board regulations. State boards usually maintain close relationships with their counterpart state associations. Some boards turn a substantial portion of their disciplinary responsibilities over to state association grievance committees and subsidize the activities of their companion associations; (Mind you, this is not just nursing; this is speaking in general.) in other cases, state associations subsidize the investigative operations of their counterpart licensing boards. Often office space, employees, and facilities are shared.[2]

What the paper is pointing out is the interlocking relationships of the profession, the state association and the licensure boards. While licensure is a public responsibility, it is conducted by the profession for the purpose of protecting the public, but cannot help but be influenced by attitudes that are developed within the profession regarding their own economic, political and social welfare. The paper continues:

> On the national level, national health professional associations may be given substantial responsibility for disseminating information on state board requirements and activities, operating interstate reporting services, preparing examinations for use by state boards, and evaluating the credentials of foreign-trained health professionals.[3]

The various licensure boards are not completely patterned after medicine, but we do in many cases note that they follow the pattern established by medicine. There are all kinds of interlocking relationships. The paper further states:

> In many respects, national accreditation has served state licensing agencies well. The accrediting programs of health professional associations have relieved most state licensing boards of the responsibility for evaluating educational programs and the expense of mounting their own full-scale accrediting programs. Whereas the incorporation of specific coursework requirements into licensing statutes may ossify educational standards and inhibit necessary and desirable educational innovation, the requirement for national accreditation provides a built-in mechanism by which educational prerequisites for licensure may be kept automatically abreast of changing educational needs and requirements. Moreover, there is little doubt that interstate mobility has been greatly facilitated by the existence of national education standards and norms. By providing state boards a readily usable yardstick for evaluating licensure candidates, national professional accreditation has, in effect, established national baseline standards for selected categories of health personnel.
>
> Still, the utilization of national professional accreditation as a criterion for state licensure may also have the detrimental effect of barring otherwise qualified individuals from obtaining state licensure. Conversely, it would appear that for those graduated from accredited programs, the licensing examination often constitutes little more than a 'technical formality' to be undergone in deference to a possibly outmoded, double-jeopardy system of quality control. In the words of one observer: 'Is (the licensing) examination a methodology for testing recall or for testing competence to serve?'
>
> From the accrediting agency's point of view, the incorporation of voluntary accrediting

standards into state licensing statutes and regulations lends authority to the standards and promotes the effectiveness and general acceptance of the accrediting program. There is little doubt that 'private accrediting activities would be far less effective if it were not for public laws recognizing and enforcing the private standards.' In addition, the incorporation of accrediting standards into state licensing laws allows national accrediting agencies to utilize the results of state and national board examinations as one means of evaluating the quality of educational programs and the validity of their accrediting standards.

Originally conceived as separate processes geared to somewhat different roles, accreditation and state licensure have, over time, become linked together in the pursuit of one overriding objective — the identification of qualified personnel and the exclusion of the presumed unqualified from practice. Like certification, state licensure no longer can be considered a self-contained process beholden primarily to professional interests, but rather must be further examined in the light of present day demands and current interlocking relationships.[4]

ROLE OF ACCREDITATION IN THE CREDENTIALING SYSTEM

In order that we may have time for general discussion, I will now conclude by identifying four propositions that have been presented at the end of this staff working paper concerning the relationship of accreditation to voluntary certification and state licensure.

1. "Through its incorporation into licensing statutes, accreditation has the power to exert considerable control over both the quality and the quantity of available health personnel."

2. "Certifying and licensing examinations often serve to validate accredited educational preparation."

3. "Certifying bodies and licensing boards utilize accreditation standards both as a screening device for prospective applicants and as a basis for examination; accrediting agencies utilize the results of certification and licensing examinations to evaluate accreditation standards, educational programs, and the overall validity of the accrediting process."

4. "Accreditation and certification are, at least theoretically, designed to promote high standards for education and practice; licensure is intended to certify minimal competence."[5]

Following each of these propositions is a series of questions to which answers should ultimately be given with the intent of further improving the delivery of health care and doing so during a period of changing economic, political and social conditions.

All of the SASHEP papers are based on the proposition that accreditation, certification and licensure have, in varying degrees, been initiated and conducted in the health professions for the benefit of the professions. At the same time, society is indebted to the professions for their contributions in these functions despite the motivations of self-service. However, the time has now arrived when the structure and operation of accreditation, certification and licensure must be revised to conform more appropriately to broad social needs.

Let me present one example — that of nursing and its pursuance in various sections of the country of recourse to the strike and other economic threats in order to gain what you consider, and in most cases justifiably so, a fairer share of the economic return than has been the case in the past. When the professions engage in these activities, and it is inevitable that they will increasingly do so in the future, society has the justifiable right to ask if these professions should concurrently exercise the responsibility of looking after the welfare of their individual members and be concerned directly about the welfare of the public.

There are those of us who believe that there is not merely an incipient but growing conflict of interests and the professions would do well to recognize this conflict so that they can effectively look after the welfare of their members first, but, at the same time, participate in a revised structure which provides an opportunity for them to make their constructive input in looking after the welfare of the public.

FOOTNOTES

1. Karen L. Grimm, "The Relationship of Accreditation to Voluntary Certification and State Licensure," *SASHEP Accreditation of Health Educational Programs*, Part II, Staff Working Papers (One Dupont Circle, Washington, D.C.: National Commission on Accrediting, 1972), I-1.

2. *Ibid.*, I-11, 12.

3. *Ibid.*, I- 2.

4. *Ibid.*, I-14, 15. Also refer to Matthew F. McNulty, Jr., "Assuring High Quality in the Health Professions Through Licensure or Certification," *Quality in Health Care I* (New York: National Health Council, 1968), 47 and to Corinne Lathrop Gilb, *Hidden Hierarchies: The Professions and Government* (New York: Harper & Row, 1966), 59.

5. Grimm, I-23, 24.

DISCUSSION

DR. PEPLAU: I believe, Dr. Selden, you said that you were proposing a new organization, not subservient to the AMA, that would have representation of all of the health professions, et cetera. Then you said something about nursing being an associate member. Are you saying then that we are not one of the health professions, that we are in a lesser category?

DR. SELDEN: If you recall, Dr. Peplau, this is a structure concerned with the accreditation of selected health educational programs and nursing is not one of these fifteen fields.

By implication we state that if nursing would wish to have its accreditation transferred to this organization, it would then be a full member, but we did not anticipate that nursing would so desire. Therefore, we were making appropriate provision for the inclusion of nursing in activities in which it is not now involved at all.

JOAN GUY (Michigan): One of the things that seems to run through your presentation, as well as that of the previous speaker, and which concerns me greatly, is that although I would not argue certain aspects of the restrictiveness of licensure and authority by professional groups in the past, I have the feeling that the pendulum never has swung entirely to the other side. I am alarmed by the discussion of licensure or "not licensure" in focusing on health care as an occupational field which should suddenly be able to offer opportunities to all kinds of people, unrestricted by traditional qualifications. Nowhere through

these trends do I see any focus on so-called quality of health care. If the professionals do not contribute this aspect to the delivery system, then how can we assure that the public good will be served in the long run?

I have a feeling that the professions are not even looked to for this so-called quality, that this is being discounted somehow in favor of seeing the health care field primarily as an occupational entity for great numbers of people who should not have to meet specified qualifications.

DR. SELDEN: I think your point is very well taken and you are hitting at a significantly important social issue which must be resolved. The question is, do we have the proper mechanism to resolve it? Let me just enlarge a bit on that and do so with an example.

I was asked to speak at a regional meeting of the National Urban League held in Atlanta for representatives of postsecondary educational institutions, primarily for black people. The reason for this meeting was to encourage these institutions to develop educational programs which would be appropriate for the students who enroll there and to encourage them, in turn, to participate in a growing sector of society — those who deliver health care. The real question emerges when you are at a meeting of that type because they wish to find opportunity for their students. At the same time, how do they meet what they consider to be the barriers preventing them from participating in these occupational enterprises?

All of us in society want health care and we want the best health care when our individual welfare is at stake. At the same time, we must remember that there are some people in society who have no health care. This is the social issue which must be resolved. It should not be resolved by a single segment of society. It should not be resolved singly by those who feel that in the past they have been disenfranchised and disqualified even from participation. The contention is that such issues, which are of broad social import, should not be made only by the members of the profession which in turn wishes naturally to improve its status and its opportunity to deliver health care. How do we face these issues?

ANNE ZIMMERMAN (Illinois): I want to comment about the reference that is constantly made concerning the division between public interest and private interest. I venture that the common good will never be served so long as one is able to separate the public interest from the private interest. I think there needs to be a blend of the two. It is when you seem to drive a further wedge between the private interest and the public interest that very sharp resistance focuses on some of your comments.

DR. SELDEN: This point can well be made. The private collective interests of the members of a health profession, in most instances, will coincide with what one might generally consider the public interest. However, when we are in a period of rather severe social adjustment where the private interest and the public interest do not coincide, these differences become more clear.

We must also recognize, regretfully, that life is filled with contentions. I bemoan the emphasis in the news media on the issues of contention because they do not give, from my point of view, a proportionate presentation. Nevertheless, let me give you an example — the hang-up that the nurses have toward medicine as a profession can be duplicated in the relationship of RNs with LPNs and so on. I spoke at the National Association of Practical Nurse Education and Service meetings in Arkansas just a few weeks ago. I concluded my comments with the point that the influence of nursing, and I am using this in the broad concept, will not be fully effective until nursing gets its house in order.

In speaking of accreditation, I also said that there are really two issues. The first one was, is practical nursing a part of nursing? If it is, then the second question is, how can nursing, assuming the incorporation of practical nursing, resolve its issues so that it does not have contending forces presented by organizations competing with each other? I cannot answer either question.

Now, let us relate this to the question of the licensure of practical nurses. Have the RNs and the practical nurses been able to resolve the contentions regarding the proper responsibility for licensure as represented in the composition of the state licensure boards and so on? Again I am not going to provide the answer, but I am indicating to you that these are issues which possibly can be resolved only by the involvement of other people as well as nurses.

TED HEIMARCK (Minnesota): I am the first lay member of the Board of Nursing in the state of Minnesota. It strikes me that your comments are highly appropriate and timely, that the professional interests of any particular group do not directly overlay public interests. This is true of nursing as it is with medicine and the law. It is high time we began to examine issues in the kind of detached way you have examined them and so separate out those issues of broad social import from those issues which evolve around private interests and financial gains from members of the profession.

PHYLLIS TOWNSEND (Michigan): I take the position with reference to the comments from the Illinois representative that the public good is not necessarily well served by the private interests. I am speaking directly to these aspects: accountability, accessibility and distribution of health care.

A case in point is the era of specialization in medicine that we have witnessed for better than twenty-five years. It has only recently been reversed slightly by attention to the development of the family physician. Specialization has made it very difficult for anyone in our nation, I speak not of the deprived citizens, but of the middle class citizens, to gain access to adequate and competent medical care. There is multiplication of fees because of the proliferation of specialists' services and no, or relatively little, accountability in the area of the types or amount of surgery done. In summary, I have taken the position that we would be very well advised as a profession to be sufficiently detached and objective to recognize that our primary responsibility as nurses is to the patient.

There was applause earlier this morning when the speaker made some reference to our primary obligation not being to the physician or anyone else, but to the patient. So, I am suggesting that your remarks are very soundly based. If we do not address ourselves to these broad social issues in which we must divorce ourselves from self-interest, I truly feel that we cease to be a profession in the true sense of the word.

DR. SELDEN: This prompts me not to respond, but to add a corollary.

Regretfully or not, the profession of nursing is predominantly female. Whether that is a comforting factor or not, I am not able to judge. Within the profession of nursing there is not only numerically but qualitatively a competence which makes it possible for the profession to

exert an influence along the lines of which you have just been speaking, as almost no other profession can do. This factor underlies my concern on the political side that nursing get its house in order, not that it can more readily throw its weight around, but that it can exert its influence as expressed by you and by many other nurses who are sensitive to these issues.

The conference reconvened at 2:00 p.m. Michael R. Buggy, a member of the Executive Committee, presided.

MR. BUGGY: Marvin Fish, our first speaker this afternoon, is a member of the permanent faculty of the Health Law Center of Aspen's Systems, Inc. He has been a member of the faculty of Seton Hall University School of Nursing since 1955, teaching legal aspects of nursing.

Mr. Fish is the co-author of "Nursing Defined" which was copyrighted in 1955. He was the research assistant in the preparation of the textbook *Nursing Practice and the Law* by Milton Lesnik and Bernice Anderson, published by Lippincott Company.

He is a director of the New Jersey League for Nursing and is counselor to the Licensed Practical Nurses Association in New Jersey.

The second speaker, Charles E. Harmon, is Director of the Department of Licensing and Regulations for the State of Michigan. Mr. Harmon is also president of the Council on Occupational Licensing.

NURSING VIS-A-VIS MEDICINE: A PROPOSAL FOR LEGISLATION

Marvin S. Fish, J.D.
Slavitt, Slavitt & Fish
Counselors at Law

In order for one to understand and deal with any question of licensure, there must first be an understanding of the authority of government to deal with the issue. That authority, as you know, is called the police power. It is an inherent attribute of original sovereignty and is possessed in its purest sense by each state and not by the federal government. Its exercise must be directed toward the promotion of the health, safety, morals or general welfare of the public. If not, then it must either rest upon some other foundation or it must fail. On occasion the foundation has unfortunately, been financial. An example would be the Medicaid system and the use of federal grants. State governments have exercised power in our democratic society through the enactment of statutes by the legislatures which represent the citizens.

Activities which are of concern to the public welfare are controlled so as to protect and to foster public interests. Examples of such statutes are licensing laws which regulate human conduct in the areas of medicine and nursing, just as they deal in concept and in practice with the operation of beauty parlors, restaurants, places of public accommodations, other occupations and professions such as the practice of law. The principles are the same whether the activity involved is your driving a motor vehicle, my practicing law or care rendered to a patient. In addition, the basic format is the same. The particular activity under control is identified by definition. Prerequisites are established for one to satisfy before the privilege is granted and a system of continuity of control is established, so that the public continues to have a voice in determining its own destiny.

Since statutes cannot realistically be altered, amended, expanded, revised, revoked and applied on a daily basis, a separate division of governmental authority has evolved to fulfill that role. It is known as the administrative branch of the government and its creature is the administrative agency as established by the legislature. Such agencies implement the statutes in accordance with specific powers granted to them and they have only those delegated powers. If the legislature does not invest the agency with a power, it does not exist.

Once established, an agency may be quasi-legislative as well as quasi-judicial. It may have the power to issue regulations similar to statutes. It may render decisions after conducting hearings much the same as courts of law. However, in order to take either course of action, the agency must be given the power to so act by the legislation which created it.

Boards of nursing are examples of administrative agencies. Their creation and their powers must follow the principles which I have just outlined. Professor Nathan Hershey, in his monograph published in 1965 entitled "Towards Better Definition of Nursing," stated, "Nursing and medical practice legislation does *not* contain explicit authority for nursing and medical boards to interpret statutory definitions in the light of specific techniques and procedures."

The American Medical Association Board of Trustees and the House of Delegates in June, 1970, approved a position statement entitled "Medicine and Nursing in the 1970's" in which they also recognized that particular functions which a nurse may legally perform are not delineated in state statutes. If the vehicle which protects is the statute and if the board of nursing is the driver, how does that driver determine which road to travel? The pathways followed, the route circumscribed, the trail behind and the direction of travel are what we refer to as the scope of practice.

Let us look at the means which have been employed in the past (some employ them today) to acquire these answers.

1. **Opinions of Attorneys General.** What are they? They are merely opinions. They are not true sources of law. They are not available to individuals who have specific questions which they must ask and the answers to which are important to their daily activities. They answer the governmental officials and governmental agencies.

No attorney general nor his entire department can know the answer to everything and understand each and every issue. If they turn to professional organizations for assistance, they may procure the proper direction. If not, they still must act. In any area of law or activity akin to law, even the failure to act is action. If an individual seeks relief and no action is taken, that is the same as denying relief.

2. **Judicial Decisions.** A second source to which we have turned, in an attempt to procure answers to the question as to what is within our scope of practice, has been courts of law. This is also inadequate. Courts of law handle specific cases. The particular case which is evaluated by a court may not be evaluated until the passage of two, three, four, five, six and, sometimes as long as, seven years after the incident in question has occurred. When the court of law speaks as to that incident, it speaks as to what the law was at the time the incident occurred. Therefore, what are you to do in the intervening years if you are to await the decision of a court of law? Even if there were an adequate answer, can you be sure that a particular court of law will be properly advised when it renders its decision? It is the obligation of an attorney, as an officer of the court, to advise the court. Experts are used for the purpose of presenting testimony in a court of law, but in our adversary system it lies within the exclusive domain of the jury to choose which experts they will be guided by and upon which they will rely. The experts themselves may not be qualified. Nevertheless, a decision may be rendered.

Nurses' associations on the state and national level can play a very important role in assisting courts of law in rendering their decisions, much the same as they play indispensable roles when they assist the legislature in coming to a determination.

I submit that it would be an excellent idea for the associations to offer their services in a pending case as *amicus curiae*, or friend of the court, for the purpose of presenting "impartial views" as to the issues being presented should they affect the public, nursing and other similar areas of activity in health care. This is not a novel idea. The American Bar Association is alert to pending cases and does offer such assistance for the welfare of the public. I recommend that you explore this possibility. If you do not, a court of law will still come to a decision. If you do not agree with the decision, it will be too late. Under the principle of *stare decisis*, courts of law, thereafter, will look back to other courts of law in order to determine which principle should be applied.

3. **Use of Private Counsel.** It is only an attorney who gives legal advice and it is only advice that he gives. He does not give you the protection of law. Even if advice did give protection there would be no uniformity inasmuch as there can be a difference of opinion between attorneys. You would lose the benefit of predictability. If the attorney was not adequately informed, he could be misled or misleading.

4. **Joint Statements.** A joint statement such as that adopted by the New Jersey State Nurses' Association on October 13, 1967, approved by the Medical Society of New Jersey in 1968 and the New Jersey Hospital Association on June 12, 1968, stated that "external cardiopulmonary resuscitation (including defibrillation) is primarily a medical procedure." It went on to state that registered nurses could use the technique under certain circumstances.

5. **Statements by Individual Associations.** In February, 1969, the *American Journal of Nursing* reported that the Ohio Nurses' Association had decided that registered nurses who had special instructions could begin closed chest cardiopulmonary resuscitation procedures in hospital coronary care units when a physician is not immediately available. In December, 1969, the *American Journal of Nursing* reported that the Association of Operating Room Nurses had developed a new definition of professional operating room nursing.

6. **National Commission.** In February, 1970, the *American Journal of Nursing* reported that the National Commission for the Study of Nursing and Nursing Education had suggested that a national joint practice commission with state counterpart committees be established between medicine and nursing to discuss and make recommendations concerning the congruent roles of the physician and the nurse.

7. **Other Associations.** In June of 1970, the American Medical Association Board of Trustees and House of Delegates approved a position statement for its committee on nursing entitled "Medicine and Nursing in the 1970's." They stated as their second objective that the AMA recognizes the need for and will facilitate the expansion of the role of the nurse in providing patient care. On October 6, 1970, the American Association of Deans of College and University Schools of Nursing passed a resolution. The sixth "whereas" of this resolution stated that they recognized their responsibility to communicate the proper role and functions of nurse professionals in the interest of improving health care. On October 27, 1971, the Michigan Nurses' Association House of Delegates adopted a position on nursing practice and stated as one of its "central assumptions," that the nursing profession is responsible for defining the scope of nursing practice.

What have the courts had to say about this? In 1961 a decision was rendered in California in the case of *Magit vs. the Board of Medical Examiners*. The case involved a physician who had employed the services of three anesthesiologists, who were highly qualified graduates of medical schools, to assist in the administration of anesthesia. Before hiring these individuals, Dr. Magit assured himself that this was done in a widespread manner in that area of California. Still being concerned, he consulted the attorney for the hospital who gave his blessing. The result was that Dr. Magit was brought up on charges by the medical board and his license to practice medicine was revoked. He pleaded and said he did it in good faith. He said that he relied upon the advice of an attorney. Dr. Magit said, in essence, that everybody does it. This rationale did not satisfy the board of medical examiners. His license was revoked. The board action was appealed to a court of law. The court of law also found him guilty of participating in the illegal practice of medicine. They felt the penalty was a little bit harsh. Nevertheless, they did find him guilty.

A similar decision was rendered in Washington in 1966 in the case, *Barber vs. Reinking*. This was the same basic type of situation as the previously mentioned case. A licensed practical nurse working in a physician's office gave an intramuscular injection, in the course of which the infant moved and the needle broke. It was not easily extractable. The procedure took quite some time and subsequent additional surgery before the situation could be rectified.

The question arose as to whether or not that nurse was negligent. Among the defenses she presented was that she did not know the child would move. The court said that she should have foreseen it. A reasonably prudent nurse acting in the same or similar circumstances would have foreseen it. She was held negligent.

The court could easily have stopped at that point, but they did not. Why? Because the nurse also said in her own language that everybody does it, and presented evidence to that effect, to which the court said that it is prohibited under the statute. Therefore, if it is prohibited, the mere fact that she did something which was prohibited was not the way a reasonably prudent nurse would have acted under the same or similar circumstances. The violation of the statute was used as evidence to assist the court in buttressing the foundation upon which rested the nurse's liability.

This is what courts have done. Assuming that they have the right to speak, what has the federal government had to say about the issue? In November, 1971, the committee established by the Secretary of Health, Education and Welfare explained in the Report of the Secretary's Committee to Study Extended Roles for Nurses, "A redefinition of the functional interaction of medicine and nursing is essential; it must be couched in terms of their respective roles in the provision of health services rather than in terms of professional boundaries and rigid lines of responsibility."

What has Professor Nathan Hershey had to say about this? This is a man who has devoted the major, if not an entire, portion of his career in the health law field. He speaks on institutional licensure. He speaks as an attorney, not as a legislator, not as an administrative agency, not as an attorney general. He speaks against the concept of personal licensure in the institutional setting. For those of you who have not had an opportunity to hear his arguments against licensure of individuals, allow me a moment to list some of them. I have taken the liberty of paraphrasing some of these arguments.

1. State boards of nursing have focused more on possible incursions by other health personnel than upon the quality of the services which are being rendered.

2. Licensure is a one-time process as presently formulated by existing legislatures.

3. Controls over clinical privileges are more effective than the general standards established by licensing legislation.

4. Licensing has had an economic implication in the health insurance field. These should be separated since economics should not affect the welfare of the public.

5. Since there have been an increasing number of categories of health practitioners, legislation cannot be sufficiently specific. It would require frequent amendment and could not recognize the overlapping areas.

6. Fulfilling educational requirements plus passing an examination are too rigid to adequately handle specialty areas. This practice is in disregard of those realities of life where individuals have demonstrated their ability and yet are kept out (i.e., medical corpsmen).

Finally, Professor Hershey feels that licensure inhibits mobility from state to state and within the profession either upward or laterally.

What have the state legislatures done? There are states such as Arizona, Colorado, Florida, Kansas and Oklahoma which have what authors have referred to as "broad delegation" statutes. Rather than deal with the specific words in each state, let me tell you that generally the statutes purport to give a physician the right to determine who will carry out a particular activity which theretofore was solely the practice of medicine and subject to physician supervision and control.

I ask you as members of the public, do you feel that it is in the best interest of the public to allow a physician to make someone else a physician? Is this not similar to the days of England when one had the authority to say, "I dub thee Sir Knight." I object to such broad delegation statutes as an answer to the problem which we are discussing today.

There have been amendments to medical practice acts by creating exemptions. The principle exemption, which began almost from the day of the first medical practice act, was when an individual was acting in an emergency. We have problems in the definition of what is an emergency. There have been amendments to nurse practice acts by additions and special statutes which have been enacted for special practitioners such as nurse-midwives, pediatric specialists and physicians' assistants.

The result of all of this has been attempts to solve the problem through regulations of a board of nursing, position statements by the AMA, opinions of attorneys general, decisions of courts of law, opinions of private attorneys, joint statements by more than one professional organization, decisions of state nurses' associations, determinations by associations of specialized nurses, suggestions by national study commissions, resolutions by deans of schools of nursing and reports by committees of federal agencies — none of which has the power to act. Finally someone awakened to all of this and called a halt to it in the form of a moratorium on new legislation.

This may be preventive, but is it really therapeutic? It is a straightjacket approach as compared to rehabilitative action.

I respectfully disagree with Professor Hershey's institutional licensing approach. It is palliative, at best, since it does not deal with the process of the nurse who works alone outside of the institutional setting. Its objectives are meritorious and in the particular spheres envisioned may even be effective, but its implementation need not and must not result in the submergence of boards of nursing. It can supplement, but it cannot substitute. If boards of nursing have not done their job, it is only because of their position, the undue influence of politics and self-interest, the burden of the shackles of history which have not been shed, and most important, because they have not been given the powers which they rightfully deserve. If the public is concerned with the importance of continuing education, as I am, let the legislatures say so, require continuing education and give boards of nursing the power to implement it.

It is Mr. Wylie, who spoke today, and the AMA who have said that there are no legal barriers. Yet Mr. Wylie said this morning that we should get rid of both traditional and legal barriers. I submit that there are legal barriers and they can and must be overcome.

Almost one year ago Idaho amended its nurse practice act to allow nurses to engage in areas theretofore clearly reserved for physicians. A means was created whereby the activities could be designated by the action of the board of nursing and the board of medical examiners. The legislature

gave to the board of nursing the right and obligation to implement the decision.

If the trend is to be in the direction of more specific legislation dealing with specific areas of health care, such as physicians' assistants, it can be done with specific statutes such as those implemented in California and Florida. Here each person is reviewed in relation to another before specific authority to act is given to those persons. Thereafter, means for continuity of control, evaluation of service and required continuing education are provided. Perhaps, when Florida evaluates its history in June, 1973, and California in 1975 we will be in a better position to judge.

JOINT COMMISSION FOR DESIGNATION AND IMPLEMENTATION OF MEDICAL-NURSING ACTIVITIES

I submit that the proposal which was made by me on September 22, 1965, before the Pennsylvania Nurses' Association, reprinted in the official publication of the National Federation of Licensed Practical Nurses in March of 1968, is still meritorious. At one time my humility deferred me from advocating this other than to my students. However, Jerome Lysaught wrote to me last March 30, 1971, and referred to my proposal as a "most prophetic" statement. Since Biblical history shows that the advice and admonition of prophets were rarely heeded, I do not feel too badly. Besides, I really cannot consider myself a prophet. I do agree with Mr. Lysaught, however, who commented in that same letter that if my advice is not taken soon, we may have far more occupations involved in medicine and nursing. You see the growth of physicians' assistants and inhalation therapists, just to mention two examples. Perhaps, it is Mr. Lysaught who is the prophet.

What was the proposal? How does it conform to the principles which I have enunciated here today and why do I feel that it is a solution? In order to understand it, allow me to go back for a moment to give you very briefly the structure of government, the foundation upon which our system of justice has rested not only in this country, but in the law of England, the basis for this country's law.

We have a democracy. One of the branches of government is the legislature. The legislature speaks as a representative of the public. If the public desires something, it has a voice. It should use it. The legislature is its ears and its mouth through which it enunciates that which the law shall henceforth be (I am intentionally and accurately using future tense as compared to my analysis of the court system which used past tense). When the legislature enunciates what the law shall be, it then creates an administrative agency to handle the day-to-day activity of implementing the statutes. There are hundreds, if not thousands, of state and federal agencies doing precisely that — conducting the day-to-day business of implementing a statute.

That agency is like a robot. It can only have those powers which are given to it by representatives of the public. So I see the solution as being only in the hands of an administrative agency established by the legislature. I have given the agency a title — the Joint Commission for the Designation and Implementation of Medical-Nursing Activities. This agency, established by the legislature, should be comprised of representatives of the nursing profession, the medical profession, hospital administration, the lay public and any other groups which would have an interest or could make a valuable contribution to its objective. This agency would have among its tasks the determination, in advance, as to what it permitted and what is prohibited. The agency would hold hearings, receive the benefit of advice given to it from all areas of life, and ultimately make a determination in the form of an administrative regulation which would state which activity can be done and subject to what prerequisite.

In essence, the above proposal (less some of the mentioned requirements) is what Idaho did. This is being done slowly. It is being suggested on a broad scale. If you will recall the things you heard this morning, if you will read some of your other literature, you will find that people have been dealing with the idea for years, but no one has ever enunciated it. In my opinion, it can be effective and workable. Yes, it may still be, as Professor Hershey's concept of institutional licensing, just a theory. There is no reason why the theory cannot become a reality. If it ever does, then I would like to add to it the realization that the identical problem exists in determining whether or not, in a particular case, a licensed practical nurse is or is not practicing professional nursing without a license in a mandatory licensing state.

In the area of medicine *vis-a-vis* nursing, physicians have been able to completely avoid liability where they have been able to convince a court that they should have a right to rely upon the competence of a professional nurse. It is in that kind of a forum that the physician speaks so highly of the nurse upon whom he must rely and, therefore, should be absolved from liability. I do not imply that the physician does not say it elsewhere, but I imply that he does not say it everywhere. The result of such a decision, absolving the physician, is a recognition of the professional competence of the professional nurse and I have no objection to it. It is a reality that you are entitled to live with and a risk which you must also bear; but, the same advantages should be given you when you delegate authority to a licensed practical nurse. You do not have it because you have wasted twenty years worrying about going to jail for practicing medicine without a license instead of spending that time to determine when you could have a right to delegate functions to other personnel and have the legal assurance that you could rely upon them without fear of liability.

And so I suggest that an agency likewise be established where nurses would be able to have the authority granted by the legislature to determine which activities fall within which area of the overall profession of nursing.

The statutes as they exist for the time being may stay as they are. The moratorium can be dissolved and progress can be resumed in your capable hands.

DISCUSSION

REBECCA CULPEPPER (Tennessee): When you talk about medical-nursing determinations, what is your rationale for proposing a separate commission relating to professional-practical nursing?

MR. FISH: You have no legal justification now, whatsoever, for the transmission and delegation of authority from professional nursing to practical nursing. There is no legal justification for a board of nursing exercising the absolute right to determine, as a matter of law, that a particular activity belongs in a particular classification.

I propose you should have such authority. My rationale is that I want to give you the protection of the law.

MRS. CULPEPPER: My frame of reference was established when I was chief lobbyist for our organization at a time when we were to change or achieve an amendment to our Nurse Practice Act. The so-called definition of professional nursing, and we included language which had to do with the supervision of others, but did not include the term 'delegation of activities.' What language are you saying should be in the laws in order to give such authority to an administrative agency?

MR. FISH: I will not give you the exact language because I did not formulate it, but I will give you the concept. The concept is a working agency, not meeting once a year or once every two years, but meeting daily, if necessary, in order to deal with a particular activity and answer the question whether or not an activity can be delegated, to whom, and subject to what prerequisites.

This working agency would have that power. There is nothing in the Tennessee statute which says who is to decide which activities are to move from one area of nursing to another. I think that is a serious omission.

MRS. CULPEPPER: Some people hold to the belief that professional standards precede legal standards. I am hearing you say this would not be the case in your model.

MR. FISH: It depends on your definition of precede. If you mean chronologically, you are factually correct, but professional standards do not give the protection of law until they are enunciated by the voice of the law.

SADIE READING (Florida): I was extremely interested in the idea of the new agency and was wondering whether or not the same kind of legislative authority could be given to the board of nursing and the board of medicine so the two of them could act together?

MR. FISH: That is one way it can be done. It was done that way in Idaho. I am sure you are familiar with your own physicians' assistants law in Florida. That same concept of continuing evolvement, control and evaluation of particular activities is incorporated within that statute, but it does not answer the rest of the questions I have raised today.

LIONNE CONTA (California): When you spoke about the administrative agency, you mentioned composition. You spoke about nursing, medicine, hospital administration, lay public and anybody else. One of the greatest problems that we seem to have among ourselves, as nurses, is the involvement of others. When we think about medical-nursing practice, we do think of the involvement of physicians and registered nurses, but the idea of getting others involved causes us to run into lots of hangups. Would you talk to us some more about your concept of the composition of such a group and the importance and value that you see in having wide spread involvement; also mention numbers of people and comment on whether nurses might become outnumbered.

MR. FISH: I am really not a psychologist. Therefore, I cannot answer your question exactly, especially when you have used terminology which is a window to your mind; namely, "hangups." It is too late now to change those words, but I can tell you of situations where I have changed complete practices in hospitals by the manner in which something was said to someone, the way in which you deal with people, your own self-evaluation, the evaluation of others.

In everything you do, speak as though you are listening, write as though you are reading, and gesture as though you are viewing. That is the concept.

If you think in terms of yourself — what do I say, what do I feel, what is good for me, how do I see it through my eyes — you can be sure that the person to whom you are communicating will be deaf and dumb. You must project yourself beyond yourself. When you act in a representative capacity, you may have hangups, yes. If they are too strong, you do not belong on a public body.

DR. PEPLAU: I am not at all clear, Mr. Fish, if your joint commission would take the existing laws that now govern the practice of nursing, medicine, hospitals and whatnot in the state and then be the implementing agency. Is that the idea?

MR. FISH: It is not.

DR. PEPLAU: Then I am not at all clear about how this would deal with the legal barriers which you talked about before. I wonder how this joint commission would be different from what the DHEW Secretary's commission did. I am sure you read the Secretary's report on the extended role and the interaction between the role of nurses and physicians. How would this be different? What would be its relationship to existing laws that regulate the practice of the professions which would be represented on that commission?

MR. FISH: The agency which I have suggested is one which implements the statutes. I ended my few words today by saying that we need not, for the time being, disturb existing statutes in order to accomplish my objective. The activities being conducted presently by boards of nursing can continue to be conducted, except for the activities in which they are engaging for which they have no authority. The new agency, which I propose, will have that authority.

I do not see the extent of the role of the federal government when the Department of Health, Education and Welfare agrees that it cannot implement statutes. There are those who are strong "states' righters" who would not want the Constitution to be changed to allow this activity to be handled by the Department of Health, Education and Welfare. They may make recommendations, but I do not believe that any of their recommendations specifically include the creation of the type of administrative agency I have envisioned.

VERONICA DRISCOLL (New York): I would like to go back to your question of the delegation of activities to the licensed practical nurse. I do believe the present legislation that was passed in New York State, the New York Nurse Practice Act, does not provide for this delegation by the professional nurse to the licensed practical nurse. I do not know whether you are familiar with that legislation. Although I am not an attorney, I would challenge you that this law does not give the professional nurse the opportunity to delegate to the practical nurse. I think the problem is in the concept of non-nurses interpreting what the practice of nursing is, whether they are lawyers or anyone else.

In the definition of nursing is contained the scope of nursing practice. If you believe that within the profession and practice of nursing you have practice by a variety of levels of practitioners prepared in different ways, then you can have delegation of the highly qualified to the less qualified.

In New York State the scope of nursing within the realm of the licensed practical nurse is defined as performance of tasks within the framework of the total scope of nursing. These tasks would come under the direction of the registered professional nurse. I do contend that this direction would give the professional nurse the delegation power. According to the reality of the situation, the original proposed legislation included delegation by the profession of nursing — that we had to compromise. However, I do believe that if it were tested, there would be no question about the professional nurse delegating to the practical nurse.

MR. FISH: I submit that you do not have within the statute anything more than an "I dub thee Sir Knight" concept. I do not believe that it specifically states that a professional nurse can, within her own discretion, determine activity which may be given to a licensed practical nurse.

MISS DRISCOLL: I think sometimes we have to take the legal advice carefully. I think you spelled out that individual attorneys render individual opinions. We have had five different interpretations of the definition of nursing in New York State. That shows the difficulty that lawyers have in understanding the practice of nursing.

MR. FISH: Even if I am wrong in what I said about New York, then I can still say that if New York is as you say it is, this proves it can be done and we should all do it.

JOAN GUY (Michigan): Without belaboring the concept of the commission you suggested, I would like to have clarified the difference between what the continuing boards of nursing would do as compared with your concept of a commission. Are you suggesting that this commission would, in a sense, serve as a mediator or arbitrating kind of agency to make decisions regarding those undefined or gray areas of practice which exist between nursing and medicine and cannot be resolved by either board within the context of their statute?

MR. FISH: Yes, except that I see them doing more than just mediating, rather I envision this commission making decisions.

MRS. GUY: Would they decide secondarily to the inability of the individual professional boards to make a determination within their statute covering that practice?

MR. FISH: Yes. No state board has been given that authority (to my knowledge). Therefore, your question is academic. I say that no state board has specifically been given the authority to determine what is nursing and what is medicine. Therefore, there is no conflict. I say that the authority does not exist anywhere and I am proposing that it be created.

ROSALIE DARRY (Louisiana): Should your commission come to me with the power to implement, would this require policing powers? If so, would you discuss policing powers with regard to this commission?

MR. FISH: I am concerned with the word "policing." If you mean from the standpoint of continuity after a determination is made, then, yes, it would have that function. I alluded to this when I spoke about trends in continuing education. It was also my intention that you realize that among the activities of this commission would be the "thereafter;" namely, to deal with (within its prerequisites) a system of continuing education as a requirement for the fulfillment of the particular task assigned to an area of care that had, theretofore, not utilized that activity.

MISS DARRY: Would this be done on a state basis or would this be a national commission?

MR. FISH: Let me make the record clear: I did not say "national." If anything, I am saying the exact opposite, every state to itself. But I would wish that you work for uniformity if it is at all possible, realizing that you may have particular differing problems in different parts of the country.

SARA ERRICKSON (New Jersey): How will the members of this commission be appointed?

MR. FISH: How do you think they should be appointed? If an individual feels that he, as an outsider, can answer that question without first asking those who know, then he makes a mistake.

MRS. ERRICKSON: We would hope that nurses, with their expertise, would be able to select the best members of their profession to function on such a commission rather than the governor or the legislature doing the selection.

A DISCUSSION OF OCCUPATIONAL LICENSING

Charles E. Harmon
Director
Michigan Department of Licensing and Regulation

I come here today as Director of the Michigan Department of Licensing and Regulation and as President of the National Council on Occupational Licensing.

I come to you as a generalist. Some of the other capacities that I currently hold are Special Assistant to the Governor of Michigan on Consumer Affairs and membership on the Michigan State Health Planning Advisory Council. I also serve on various other boards and national licensing associations. For example, I am responsible for the licensing of residential builders, psychologists and nursing home administrators in Michigan.

In talking about occupational licensing, I am reminded of the fact that the Chinese use the same ideograph for "trouble" and for "opportunity." For occupational licensing presents a basic paradox. On the one hand, the law protects the public and, on the other hand, it restricts the freedom of the individual to work unless he or she meets certain requirements imposed by the law. Ideally, there should be an unending effort to arrive at some kind of operational balance, to reconcile freedom and regulation, to protect the public interest without destroying the private interest. I speak to that whenever a bill is introduced in the Michigan Legislature proposing to license some occupation for the first time. We usually have an average of 24 to 36 bills in the hopper. Recently I testified on bills before various committees proposing to license collection agencies, park and recreation workers, auctioneers and even horseshoers.

Whenever I go before a legislative committee, I request that the lawmakers, before going any further, seek affirmative answers to the following two points in considering a new licensing law: 1) the failure to enact such a statute would present a clear and definite danger to the general public health, safety or welfare, as distinguished from the interests of a particular group or segment, and 2) specific

qualification standards can be established and there is reasonable assurance that persons meeting such standards would be able to function effectively in the occupation while those failing to do so could not function. These issues manage to kill off quite a few of what I call "prestige" license acts.

CATEGORIES OF STATE LICENSING LAWS

I see three basic categories of state licensing laws throughout this country that have developed over a period of more than a century. One category is to establish standards that will assure the public that the people practicing are competent. Most of the health related licensing laws deal with or fall into this type of category.

A second type of licensing act is essentially of a regulatory nature. Under this category the licensing or qualification standards are usually minimal. The laws are essentially written to protect the public against the practitioner once he is operating in that field. This is why, for example, there is a bill proposing to license collection agencies. This type of act deals with prohibitions that would be imposed upon the people operating in that field.

The third category is what I usually describe as the "prestige" license bills. Nobody would be worse off if the bill had never been enacted, but some group convinced enough legislators and the governor that they should be licensed. Hence, we have a proliferation across the country of all sorts of licensing laws.

Realistically, occupational licensing is too frequently an orphan of government. Despite the relative age of this area of public responsibility, despite the sheer numbers directly or indirectly affected, despite the revenues derived, little effort and less imagination have gone into bringing reason and common sense to this field, much less innovation and modernized methods. I believe, however, there is indication of growing interest in occupational licensing and its effects upon society.

When I came into my job in January, 1969, I wanted to become an expert in my own state. I began to seek out the expertise of others, particularly in writing. I found the libraries very thin and that little interest had been shown in this field. I am not speaking about licensing of nurses or doctors. I am talking about the field of licensure in general.

I was very sorry that I could not be here this morning to hear the discussion on the DHEW Report because I have read and re-read it. The fact that such a report came into being, I think, is an indication of something.

I am aware of two imminent reports resulting in studies on the effects of licensing on manpower needs and manpower mobility. One report, sponsored by the U. S. Department of Labor (not necessarily relating to your field) indicates that the government, at least nationally, is getting more and more concerned about the effects of licensing laws upon job opportunities, particularly in vocations. Another example of what is going on in this field is a new survey, under the sponsorship of the American Bar Association through Georgetown University, to study restrictions facing individuals with criminal records. One of the areas the study will deal with in the next twelve to eighteen months is the restrictions in the license laws on the ability of people with criminal records to obtain employment, whether in nursing, plumbing, building, medicine or whatever.

Additionally, and this is a sore spot in some states, we hear that the trend is toward centralization of licensing functions. There are many states that have not gone through this, but Michigan did as a result of a constitutional mandate that was approved by the people of the state in 1963. The new constitution mandated that there could be no more than twenty principal agencies of state government. On January 1, 1966, nineteen departments came into being. The Michigan Department of Licensing and Regulation was one of those agencies.

This was more than six years ago and we are still shaking down because it was not an effort that was really done wholeheartedly or with great feeling on the part of the legislature. It was done because the constitution said it had to be done. We now have, more or less, a holding company for thirty-three different licensing laws under one group. As a result, in a given month I might sit down with the State Board of Nursing, the State Board of Medical Examiners and the Builder's Board.

COUNCIL ON OCCUPATIONAL LICENSING

This centralization has been going on in several states. As a result, through the inspiration of Henry Shine, who is now in Washington, several of us got together in Seattle in December, 1969, to organize the Council on Occupational Licensing.

There are many reasons for the decision to organize, some of which I have alluded to. Probably the principal reason was the need for communication. After all, why do we assemble? Why does an organization get together? For the communication of ideas, for the development of ideas and, occasionally, for the determination that we can go forward together. We felt it was time (principally those individuals in capacities such as mine) for an exchange of ideas that would help each of us to do a better job.

The Constitution of the Council on Occupational Licensing states that the primary purpose of the Council is "to form an organization of state licensing officials for the better administration and enforcement of professional, vocational and business license laws." More specifically, some of our goals are: to establish communications with respect to new laws and revisions of existing statutes; to furnish data on basic administrative problems; to work in the area of interstate cooperation in determining equivalency and in establishing standards pertaining to reciprocity agreements; to develop and promulgate criteria for the creation of licensing categories and licensing boards; and to improve standards for regulatory programs and for administration of hearing processes.

We are still a struggling organization. We have grown to seventeen member states, with a few others currently indicating interest. Therefore, let me make it clear that our purpose is not to infringe upon the prerogatives of organizations such as yours, but rather to improve ours, so that we can do a better job of helping you and in so doing, help the public we all serve.

FUTURE GOALS FOR OCCUPATIONAL LICENSURE

I would like to make some brief concluding comments on this whole area of licensing and where I think occupational licensing ought to be moving generally in the second half of the twentieth century — what goals ought to be set. I am speaking generally now. In so doing, I will make a

couple of reference points to some of the directions that have been noted in the DHEW Report on the question of state prerogatives and state rights as contrasted to the federal level.

In my humble opinion we should proceed to meet at a minimum these goals:

1. We must appraise more intelligently and less emotionally those activities proposed for governmental regulations.
2. We must reassess the criteria and guidelines for determining competence.
3. We must remove artificial barriers that separate the licensed workers from state to state.
4. We must give the consumer a greater voice in supervising those occupations that touch the public every day.

From this standpoint, it is my fundamental belief that every licensing board in this country ought to have at least one public member on it. I think the public must be represented. If somebody does not take the leadership in the occupations, somebody is going to demand that they give it. It may even come much more harshly than that. Finally, I feel that we must ensure that, as we seek to promote competence, we do not raise false barriers to job opportunities and job mobility.

I think the DHEW Report is very interesting. I do not think anything is going to happen to it because the rights of the states still exist. For example, how ever right or wrong the Report may be, the legislature of Michigan is not going to declare a moratorium and I do not think I am going to be in my job the day institutional licensing comes into being in the way that Report describes.

I am not just defying the Report after sitting back and having read it two or three times; I am saying, from a practical standpoint, it is not going to happen under the current setting. I think it is a starter, but it is not going to happen. In my opinion, the nursing home administrators' licensing law was a foreshadow of what may be coming. For the first time in the history of this country, the federal government in effect mandated that states license an occupation.

If some steps are not taken by the states in certain areas of concern, such as reciprocity for interstate mobility, the steps will be assigned from Washington. This move has been coming in every other direction. Who is to say it is not going to come in the area of occupational licensing. Certain basis requirements will "come down from on high" unless the requirements are set by the states themselves and by organizations assembled to represent the various states.

I am a little afraid that it is going to come too much from the other direction. According to what some people say, every health-related occupation is going to have to license. Most ambulance drivers may have to have a high school education, the way licensing laws are written today. The conflicts in the area of health-related occupations, that I see, are going to have to be resolved. Perhaps, the commission Mr. Fish talked about is the answer. Frankly, I think he is prophetic. I think essentially the commission he is talking about is long overdue.

In Michigan we have a constitution which has a very unique proviso stating that a majority of the members of the professional licensing board must be made up of a representation from the area being licensed. I do believe that all fields will need to have guidelines that deal particularly with questions of people going across state lines and questions that involve the consumer interest. The consumer is going to demand a stronger voice in the areas that affect him.

DISCUSSION

ANNE ZIMMERMAN (Illinois): I am not sure that I would agree with you that nothing is going to come of the DHEW Report. I think I need to relate an experience that everybody in the country should be looking at.

The Illinois Hospital Association did what it called the "White Paper on Licensure and Manpower." It took about a year and a half to do it. The DHEW Report does call for a moratorium. However, during the moratorium there shall be studies done over the country to prove or disprove capability of the institutions to take on licensing functions. In fact, there has been a proposal submitted to DHEW to test the capability of institutions for credentialing their personnel. DHEW is interested enough in this proposal to put in $200,000 to $300,000 over the next few years. So I think that some of these studies will turn up things that will prove or disprove what is in the Report. I also think that since DHEW is so interested in it and will be sending five people out for a site visit, it undoubtedly will be proven or disproven. Therefore, we have to have more than a passing interest in the Report on the shelf.

MR. HARMON: Yes, I overstated the case by the phraseology I used when I said nothing is going to happen with the Report. What I meant was that, as the Report stands at the present time, I do not see that anything will happen, at least, in Michigan. I think this is also true in some other states. You know, legislatures are not jumping up and saying, "All right, this is what we are going to do."

Statutes are passed by the legislature, not by licensing boards, not by me and not by DHEW. If the Michigan Legislature decides this year that it is going to pass a licensing law, a certification act or whatever to deal with the health occupations, the law will be passed.

I think the DHEW Report is a good starter. I am not demeaning the content of the Report. I think there is some great substance to it. I think the ideas are fine. I am not sure I agree with certain ideas in the institutional areas, but I think, at this point, it may promote interest in certain specific states. I am waiting for the next step. I do not think that Congress has officially reacted to the Report, has it? And the Report was sent to Congress by DHEW. I am just saying that we are going to see some further steps as we go along. The Report itself, for whatever it is, may or may not provide and promote local action. It certainly is not promoting action in Michigan.

JULIANN RITTER (West Virginia): I wonder if we are atypical. We have had two occupational license laws introduced and both have been defeated, but they also left out the medical licensing board and the bar licensing board. Do you know if this is typical of other states?

MR. HARMON: You mean a law to create a central agency? No, there is no uniformity across the country as to what these agencies consist of. For example, in California the department which houses the board of nursing is very comparable to ours. However, there are some major exceptions such as real estate licensing which in California is part of a completely distinct department of real estate. There are a few areas that we do not have that may be covered by a central department. There really is not any

uniformity. I think it gets down to the power thrust in the legislature and the concept of who can keep out of it, I suppose.

MARGARET SULLIVAN (Washington): In terms of centralization in Washington, the board of nursing, the medical board, the practical nurse board, beauticians, barbers, the real estate board and the Division of Securities are all under the Department of Motor Vehicles.

MR. HARMON: Yes, I know that you have rather an unusual bureaucratic line that I have never quite figured out. It is true in some other states, too. There are fundamental problems. I hope you do not understand that my purpose here today was to promote centralization of the license boards. I did not come to do that. There are problems that you may not see, but that we used to see at the time when I was not part of this, before we had a central department.

One of the major problems we had with centralization in Michigan was essentially this:

When the Constitutional Convention assembled in our State, one of the areas they got into was what I refer to as the proliferation of executive responsibility at the governmental level. Several studies had been made — one by the Municipal League, one by the Citizens' Council of Michigan, one by the AFL-CIO and others. A part of these studies preceding the Constitutional Convention was to determine how many executive agencies there were. Nobody could agree on the number. There was no uniform figure on how many boards, commissions, agencies and distinct departments there were. If they could not find out, how could the public ever find out how many there were? Frankly, I think the best figure they came up with was somewhere in the neighborhood of 135, ranging from 125 to 150 in various studies. This was one of the things that fired the idea that there ought to be consolidation or centralization. But, what works in Michigan may not work elsewhere.

GENEVIEVE JONES (Georgia): I may sound like an alarmist, but I do not really mean to. How much authority does the President have in issuing an executive order or declaring a state of emergency or something of this type as far as licensure, perhaps national licensure, is concerned?

MR. HARMON: I am not a constitutional attorney. I do not know how far the authority of the President goes in issuing such executive orders. I would question it very highly.

The President has a right to point to the concern. He certainly has the right to form commissions to do certain things. Whether he could go any further than that, I would question very highly.

MR. FISH: Although I do not consider myself an expert on constitutional law, I will tell you that in the framework of the Constitution there have been times when the chief executive and the legislature have acted. Some years later when a test case arose and was taken through the judicial branch of the government, the action was declared unconstitutional and void *ab initio*, right from the inception.

So you really raised two questions. Could it be done? Perhaps, but if it were done and then taken to the judicial branch of the government, in my opinion, it would be deemed clearly unconstitutional.

MR. HARMON: I might say, taking it down to the state level, that under the Executive Reorganization Act in Michigan, although subject to veto by the legislature, the governor has power to take the steps without the approval of the legislature. For example, he could shift one component agency to another by executive order. Now, this possibly could be tested. Up to this point, it has not been. We know the Governor is looking at the possibility of extending it to a much greater degree to where he could totally organize departments by an executive order. We may see attempts directed at this in the next two years.

The conference was reconvened Friday morning at 9:10 a.m. Miss Marguerite Hastings, a member of the Executive Committee, presided.

MISS HASTINGS: Our speaker this morning is Helen Connors, a staff representative of ANA's Department of Government Relations. She will bring us some information on a subject that is of immediate concern to all of us in state government and to our nurses who are here today from State Nurses' Associations. Miss Connors will bring us up to date on what is going on in Washington and such places where hard government policy is made.

THE HEW REPORT ON LICENSURE: A COMMENTARY

Helen Connors
Associate Director
ANA Department of Government Relations

If we were not aware before, we should be after yesterday, that licensing and other established ways of credentialing and assuring some accountability are under increasing scrutiny and attack these days. They are seen as barriers to upward mobility, as a means of screening out individuals from a given field because of educational requirements, and as contributing to the ineffective utilization of manpower, especially in the health field and in that field's fragmentation of care.

The DHEW *Report on Licensing and Related Health Personnel Credentialing*, as you know, was required by action of Congress taken in 1970. Congress wanted major problems of licensure and certification identified and recommendations made regarding possible solutions. The Report was not available until January, 1972. For this reason, not all structural units of the ANA (those that are most concerned with the issues of licensure and credentialing) have had the opportunity to study the recommendations, react to them and suggest the posture of the Association.

Staff at ANA have reviewed the Report and raised some questions for consideration by the Association's structural units. A staff committee was appointed to prepare a document for consideration by these units. Also, a committee of the Congress for Nursing Practice is about to be appointed which will review, revise, modify and update the Model Nursing Practice Act. This committee is going to have available to it legal counsel.

The DHEW Report is a survey of the various issues surrounding licensure and credentialing that have been widely discussed during the last few years. It contains seven recommendations directed to state governments, to agencies of state governments and to professional associations. It does recognize that the issues are complex and it offers no easy solutions. It appears to me that there was an effort to be objective in the preparation of the Report. As each recommendation was discussed in the Report, the pros and cons were presented.

MORATORIUM ON LICENSURE

The first recommendation, as you are aware, called for a moratorium on licensure of new categories of health personnel. Yesterday afternoon, Mr. Fish made the point that moratorium was a means of standing still and not doing anything. However, I think there is some justification in calling for a moratorium on the licensure of new categories of health personnel. The DHEW Report did not suggest that existing laws could not be amended for professions already licensed.

In May, 1971, before the Report was issued, the ANA Board of Directors did take a position in support of the moratorium on licensure of new categories of health personnel. This was not a radical move on the part of ANA. The Association has had a long-held position opposing licensure of additional nonprofessional personnel in nursing, such as psychiatric aides, geriatric aides, obstetrical aides, on the basis that licensing of additional personnel in nursing would lead to fragmentation and rigidity with limited and circumscribed functions prescribed by state law.

DEFINITION OF NURSING PRACTICE

Now, as the role of the nurse has been expanding into areas once considered solely within the province of the physician, concern has been expressed by nurses that they have no legal protection, that nursing practice acts should be amended to afford this protection.

The definition of nursing practice which appears in most of the state nursing practice acts is, to some extent, patterned after the presently recommended ANA definition of practice which reads: "The practice of professional nursing means the performance for compensation of any acts in the observation, care and counsel of the ill, injured or infirm; or in the maintenance of health or prevention of illness of others; or in the supervision and teaching of other personnel; or the administration of medications and treatments as prescribed by a licensed physician or dentist, requiring for all of these functions substantial, specialized judgment and skill based on knowledge and application of the principles of biological, physical and social sciences." The last sentence is, "The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures."

It is this last sentence in the definition that causes most concern. This restriction appears in the definition of practice in eighteen states. In thirteen states the word diagnosis is preceded by the word "medical." Two jurisdictions do not define nursing practice. In the definition of nursing practice in sixteen states, diagnosis is not

mentioned. In two states the definition of practice has been modified, first, to permit diagnosis and treatment under emergency or special conditions, including special training, and, in the second state, modified to read, "Such acts as have been authorized by rules and regulations promulgated jointly by the Board of Nursing and the Board of Medicine."

As medicine and nursing have evolved, nurses have moved into areas of practice formerly carried by physicians. As this was occurring, there was no great concern on anyone's part that the Medical Practice Act was being violated. With the nurse's role now expanding, involving more and more sophisticated elements of diagnosis and treatment, the concern for legal protection has increased. Licensing laws, we should be reminded, were enacted in the public interest and not primarily for the protection of the individual practitioner. The nurse who has been prepared and knows the cause and effect of her actions is not likely to be accused of illegal practice of medicine. However, no amount of approval in the nursing practice act will protect the nurse who is negligent.

Among the questions we have talked about at ANA are: Should the ANA advise State Nurses' Associations to work for legislation that would expand the definition of nursing practice? If so, should ANA advise that all reference to diagnosis and treatment be removed from the act? Or should we recommend that language be added to the definition permitting nurses with special preparation to function in the expanding role? Or should language be added that would empower the Board of Medicine and the Board of Nursing to establish rules and regulations to permit acts of diagnosis and treatment under emergency or special conditions? Or should the ANA advise SNA's not to tamper with licensing laws during this period of rapid change in medical and nursing practice? Would it be wiser to wait for the statement or the scope of nursing practice as a basis for arriving at a legal definition suitable for inclusion in a licensing law?

Another recommendation of the DHEW Report urged states to expand the functional scope of their health practice acts and extend broad delegatory power. Now, presumably, this would apply to any health practice act that could be considered restrictive. Theoretically, at least, the medical practice act confers on the physician unlimited license to practice, covering the whole scope of health care. Essentially, all other licensing laws regulating the practice of health personnel are "amendments" to the medical practice act.

The issue is, if it is the medical practice act which stands in the way of optimal utilization of the skills and competencies of other health personnel, should not the medical practice act be amended to remove restrictions on the activities of other workers? If so, how is this to be achieved? Certainly, in the case of nursing and medicine, it will require medical-nursing dialogue to come to some agreement on the legal language of such an amendment because certain language could be very controlling of nursing. A delegatory definition or the definition that gives the physician the right to delegate in the Oklahoma Medical Practice Act appears very controlling. This definition reads as follows: "Nothing in this article shall be so construed as to prohibit service rendered by physicians, trained assistants, registered or licensed practical nurses if such service be rendered under the direct supervision and control of a licensed physician."

EXAMINATIONS

The third recommendation in the Report relates to the development of national examinations and the need for continuing attention to assure that they test the knowledge and skills required to provide high quality health care.

The Report acknowledges that nursing is one of the few professions to use a national examination. At issue in the Report is that the different requirements and examinations have interferred with geographic mobility of health personnel. The Report does point out that there is very little data available to substantiate this. The need for ongoing study of the licensing examination for nursing has been recognized by the ANA Council of State Boards of Nursing.

The fourth recommendation relates to equivalency and proficiency examinations. These examinations are to test for entry into educational programs and occupational positions. States are called on to amend licensing laws to recognize such examinations. Educational institutions, accrediting agencies and certifying bodies are asked to accept alternatives to formal education for entry into career fields. There is already considerable activity going on with equivalency examinations to permit advanced placement or exemption within the curriculum. Most state nursing practice acts do not spell out curricula; rather, they state that the applicant for licensure shall have satisfied the requirements for graduation from an educational program. Therefore, nursing practice acts need not be amended to accommodate for equivalency. However, educational institutions may not wish to go this route. The Report recommends developing valid proficiency examinations. Presently, as far as I know, there are no valid proficiency examinations — I may be wrong.

In nursing there are some programs that send an instructor into the practice situation with the student who is challenging the course in order to evaluate the student's performance. This is presently an experimental endeavor. Objective criteria are not yet developed. The danger of subjectivity is present in such a one-to-one situation. Also, this method of judging proficiency is expensive in terms of money and faculty resources. In the case of individuals who have learned on the job, it may be possible to test their proficiency in manipulative skills. However, the effectiveness of a proficiency test to determine level of understanding, ability to engage in interdepent and independent decision-making, ability to collaborate effectively with other members of the health team and coordinate diverse activities in patient care is doubtful.

STATE LICENSING BOARDS

A fifth recommendation urged state licensing boards, with the support of professional associations, to take steps to strengthen the boards to allow them to play an active role in maintaining high quality health services.

Liaison between medical and nursing boards is said to be increasing as a result of the interest in and development of programs to further expand the nursing role. The ANA has supported joint medical-nursing practice committees to draw up guidelines to deal with the problems of overlapping functions. It has not actively promoted the idea that the governmental agencies assume this responsibility. At issue is whether the professions alone make the decisions or whether the governmental agencies, the boards of medicine and nursing, alone do it. It would seem desirable that

there be collaboration between the private voluntary and public official interests.

The present ANA position regarding membership on boards of nursing is that all nurses should be licensed registered nurses qualified to carry out the functions of the board as provided in the law. Most licensing boards are composed of members of the occupational group being licensed. There has been, and there was yesterday, increasing discussion of the need for representation from the public so that consumer needs will be taken into account. It has also been suggested that representatives of more than one health profession sit on each licensing board.

The accusation is made that licensing boards are more responsive to the needs of the profession than to the public. At a time when the public is very concerned about the health care it receives and the quality and cost of it, should boards of nursing have public members and should the ANA reverse its previous position? Public members serve on few licensing boards. So it is difficult to know and assess their contribution. Are they, in fact, in a position to interpret consumer needs?

The ANA has opposed appointment of members of other health professions to boards of nursing. Some of this opposition relates to the school approval function of the board and the concern that representatives with vested interests or special sympathy for one or another type of nursing education program might have an influence on decisions about approval or disapproval of programs.

CONTINUED COMPETENCE

The sixth recommendation called on the professions, state governments and employees of health personnel to assume responsibility for the assurance of a continued level of practitioner competence. The requirement that candidates show evidence of continuing education for renewal of license has been enacted in at least one state and is being proposed in others. It has been argued that since professional associations do not have all practitioners as members, they are not in a position to reach and to motivate other practitioners to keep their skills and knowledge current. Since this is the case, the argument continues, the responsibility should shift to the state through enactment of legislation requiring continuing education for renewal of license.

There are many problems associated with transferring a professional responsibility to a government agency. There can be no assurance, once it becomes a function of a government agency, that standards for continuing education developed by the profession will be solicited by or be acceptable to the state. There is no assurance, even if professional standards are accepted, that the state would have the financial and staff resources to implement the legislation. State governments are having serious financial problems. If the state requires evidence of continuing education for renewal of license, would it also assume the obligation to see that programs of continuing education are readily available? This would require a further financial commitment by the state. There is the danger that if a profession abdicates its responsibility to the state and promotes continuing education for renewal of license, a law will be enacted that is impossible to implement and concern for the competence of practitioners might be ignored. If the ANA, while subscribing to the need for continuing education, does not believe the state should make this mandatory, then it has to suggest ways and means through which practitioners can keep current.

INSTITUTIONAL LICENSURE

The seventh recommendation concerns demonstration projects to extend institutional licensure beyond present facility licensure in the regulation of health care personnel.

Several proposals have been made regarding institutional licensure. It is argued that such licensure would give the institution more flexibility in the use of health personnel. The state licensing authority would establish qualifications in terms of education and experience for individuals to be placed in these positions. Some of the proposals call for personnel licensure of only the independent practitioners who are identified as physicians, osteopaths and dentists. All other health personnel would be considered dependent practitioners, including nurses. Another proposal calls for repeal of the present licensure laws to replace these with one overall law regulating the practice of health professionals. A license would be issued in six areas: medicine, dentistry, nursing, medical technology, medical therapy and an institutional license. The institutional license would authorize hospital administrators, nursing home administrators, medical record librarians, dieticians and social workers to practice.

There are problems associated with institutional licensure. The present facility licensure by the state has not been notably successful in raising the quality of the services offered. The competence of the practitioners in ensuring the safety of the patients is another question. There is no guarantee under such a system that personnel would actually be assigned to a position for which they have the appropriate required skills. The amount of surveillance required would be beyond the financial or personnel resources of the state. Too much control would be vested in the institution and in so-called independent practitioners under such a system. Furthermore, not all health personnel work in institutions or in physicians' offices. Nurses, for example, function in schools, industry, the home and health centers. Private duty nurses are self-employed. In the public interest we suggest that all nurses should be licensed.

Staff does not think it has raised all of the questions or identified all the issues and we would welcome your suggestions and your comments for incorporation into the paper we are presently preparing.

DISCUSSION

SARA ERRICKSON (New Jersey): How can we, on a state level, insure that the appropriate representative for the consumer is not selected from the point of view of being an advocate of most governors? It is very easy for them to have a representative. For instance, in New Jersey our appointment system was changed. The governor may consult and may consider the names submitted by an organization, but does not necessarily have to select from the submitted list of names. What can we do to insure that appropriate people are appointed to represent the consumer?

MISS CONNORS: I am not certain that there is any way you can be sure. These are political appointments and the governor does have the authority. Persuasion, I suppose. I am going to suggest that you be as political as the governor.

There has been a question raised by the Council of State Governments whether it is constitutionally right for a voluntary organization to have as much authority as we have managed to have all these years. It is written into most state laws that the governor selects from a list submitted by a voluntary association.

Perhaps, some of the other people in the room might share with you how they manage to get the people on the board whom they think will make the greatest contribution.

MRS. ERRICKSON: We heard yesterday more than once about the profession protecting itself and that the law was created for the profession and so on. We know that is not true. For instance, in New Jersey we promulgated and supported a bill introduced and passed in 1902 and amended in 1955. Certainly the eminent women who sat on our Board of Nursing over the years served, and served very well, on behalf of the people. They have sat there for the protection of the people.

Now we hear that the professional organization is trying to perpetuate itself and that we want this to exist for the protection of the individual nurse. I will admit that from time to time nurses are appointed to the board who become very much interested in the political arena. I would say that we have got to encourage those who are appointed not to remain beyond a period of five or ten years. When nurses stay more than this period of time, they become part and parcel an arm of the political government. Very often they are the people who develop this attitude in the minds of the people that the organization is trying to perpetraite itself.

MISS CONNORS: I think nursing, through the professional association and the constituent state associations, has emphasized that the licensing law is in the interest of the public. I do not think we in nursing are as guilty as some of the other boards.

MISS HASTINGS: In connection with that last question I think we must recognize that it has always been a fact that people outside the profession or any particular group, whether it be a professional group or not, always assume that members of the "in-group" (the profession so to speak) are together and working toward their own interests. It is not just nursing. It is medicine, the law, the engineers and so forth.

I think this is a psychological phenomenon that I, for one, cannot explain, but it is there. I think we do have plenty of evidence and the public has plenty of evidence in the actions of the ANA and our State Nurses' Associations that nurse groups have been and continue to be one of the first organized groups to go on record in support of measures that are in the public interest. The Congressional Record in Washington will bear out, that of the health fields, one of the first groups to go on record in support of measures that have an implication for the health of our people is always the ANA. I believe in most states the same thing can be said of the State Nurses' Associations.

Would it be of help to find out whether or not we have in our group any states that have set down or enunciated any sort of requirements for the person who is a non-nurse who seeks appointment to the board of nursing? If any state does have non-nurses on its board, are there any criteria that have been established or is it, in truth, a direct political appointment from the whole citizenry?

ADELE STAHL (Wisconsin): At the present time the law provides that we have four non-nurses. One is the state health officer. So one criterion is that he be employed as a health officer in the state. The physician must be a member of the state medical society. The hospital administrator must belong to the hospital association. I personally do not feel that this is a good criterion, but that is what is in the law.

We did have legislation introduced by the Wisconsin Nurses' Association, supported by the other health professions, which would have made a specific requirement much more stringent for the hospital administrator — that he belong to the College.

I think that all of us are a wee bit too concerned about having non-nurses on our board. I know that is heresy. In Wisconsin there have been non-nurses, although health professionals, on our board since 1921. They are in the minority. However, some of the most staunch supporters of nursing and the upgrading of nursing have been the non-nurses. Many of them have been appointed and have come to us antagonistically, but we accept this as a challenge and we educate these people. Therefore, we have them, when they leave us, going out to fight our battles. It is a tremendous help.

BARBARA CURTIS (Washington): I would like to respond to several points that have been brought up. We are currently studying the Nurse Practice Act in Washington and have received a grant from the Department of Health, Education and Welfare, Region X that has aided us in our studies.

We have gone about this, we feel, in a far more orderly way as a result of the monies that have been available to us in that we have had workshops throughout the state that have tested the environment and tested the attitude towards these changes. Then at our recent House of Delegates we presented a group of concepts relative to the kinds of changes that might be made or should be made in the law.

Among these concepts were three that are particularly significant. One concept involved the whole area of the definition of nursing. The House voted to accept, in concept, the type of definition that was passed in New York. The second was a concept to accept a health consumer representative on the board. The third concept was, perhaps, the most surprising to those of us who were working on the presentation of the concepts. Our House of Delegates voted to accept the concept of mandatory continuing education for relicensure. There were several options presented, one of which was the consideration for reactivitation of an inactive license. The concept was accepted in regard to relicensure or reactivitation of a license after three years of inactivity, which I thought was quite interesting.

The relicensure or mandatory continuing education for relicensure concept, had, of course, considerable discussion. Concern for patient safety or health consumer safety was uppermost in the minds of the Delegates as they discussed mandatory continuing education for relicensure.

I think we are heading in a good direction and the kinds of discussion we have heard in the past two days have been most interesting. We are most appreciative of them.

RUTH NICHOLSON (South Carolina): We have heard some suggestions that the public sees licensure as being a matter of private interest in contrast to public interest. I wonder whether one of the reasons for this might not be the fact that we have some rather strict, carefully laid out criteria for licensure.

We are talking about continued education related to licensure. I am not sure this is the answer, although it may be one of the reasons that the public sees licensure as it does. I am referring to more than licensure for nursing. Licensure of any kind seems to fall into this category. There is little or no program for seeing that there is continued competence for the licensure. There is no re-examination. This is across the field of licensure, not just nursing.

I am not sure that continued education will measure what I am talking about. Certainly there are, in addition to keeping up with the things that are happening, physical and mental changes that occur in the individual that will change the quality of performance. We know that peer review has not worked. We know that unless a person commits a great error, he continues to practice. The employer may well be the most diligent person in seeing that the quality of a nurse's performance is that which is required by licensure. I would suggest that this profession should really be looking into measures for continued competence.

MISS HASTINGS: I am sure what you have said applies to all states. The nurse, in some instances, seems to have forgotten that she is a citizen first and a nurse second. If she has knowledge or information that is detrimental to the public good, she has a responsibility as a citizen to do something about it. I think you are indicating that there is oversight in this area.

MICHAEL BUGGY (California): I would just like to comment about the public member. We have had three public members on our board since I have been in my position, the second being a movie star, Barbara Rush.

The public member on the California Board of Nursing has to be a person who is not licensed by the department in any other profession. He is strictly a public member. In the appointments to the board the professional association can make recommendations to the governor about the professional members to be appointed to the board. Furthermore, any nurses who would like to get on the nursing board may send their own application to the governor to be appointed to the board.

When it comes to the public member appointment, this is strictly the governor's appointment and no one makes any recommendations to the governor for the public interest.

We have found that these people can make a great contribution. For instance, when the board members would be talking about accreditation of schools and problems in nursing, Barbara Rush would stop them and say, "Now you are speaking jargon that I do not understand. If you expect me to make an intelligent vote on this, you will have to explain to me what you are talking about." This seemed to make the board members stop and rethink and sometimes refocus, which most of the time is a healthy process. The current public member is active in politics. She is very much concerned about the nurse who abuses the license. She is very active in the probation and rehabilitation programs that we have for nurses who have violated the terms of their license.

MARGARET BAACH (Minnesota): For the purpose of the LPN law, we have three LPNs on our board. Their names may be submitted to the governor by their organization, and he may choose from the submitted list. We also have a doctor and a hospital administrator. Again names are given to the governor from the appropriate associations. These two people must be from a city not of the first class, so we have rural representation.

This last year we did have a public board member appointed by the governor. There are no criteria that I know of in the selection of this person. We did, at the time the legislation was entered, talk to the senator advocating this and suggested that we felt strongly that the person should truly represent the public and should be — I think our views were probably evident — a conscientious type who could come to our meetings and work very hard.

KAROL RANDALL (Ohio): I would like to ask if the lay members have been concerned with the various levels of preparation that the nurses may have when they take the state board examination?

MICHAEL BUGGY (California): The public member in California has expressed concerns when we reviewed the results of an examination and found a high failure rate in a particular school. She is not so much concerned about the different preparations (A.D., diploma and baccalaureate), as she is concerned with a particular school that has a high rate of failure on the state board examination. I think that other than that, her concern is that people who are granted licenses meet the requirements that are set down in the regulations.

MISS HASTINGS: In other words, the concern of your non-nurse member is essentially the same concern of the nurse member relative to the achievement or lack of achievement of the graduates of a particular program at a given time.

DR. PEPLAU: It seems to me that the overriding issue in the discussion this morning is our concern for some continuing self-regulation within the profession and the coercions and pressures for greater external regulation. I wonder whether there ought not be some kind of a study committee to take a look at this whole matter. How much of a balance between self-regulation and external regulation can be achieved in this particular time or will there be a government takeover with the professions being totally regulated?

I think there are so many complex issues related to this, as Miss Connors pointed out this morning, that all of these issues have to be studied with great care. I think she also indicated that the American Nurses' Association has really been in the forefront, that most of our self-regulation activities seem to be more in the public interest than self-interest. I think this issue needs to be studied — the trends, directions and what can be done to propose some kind of a balance between self-regulation and external regulation that would indeed serve the public well.

MISS HASTINGS: You have heard Dr. Peplau indicate that the time has probably come when a committee may need to be initiated to consider the weighing of the issues brought before us in this particular case concerning non-nurse participation in the direction of nursing. It is very well taken that as this issue does develop, undoubtably those of us who have been involved in it for so many years should come out with some direction as to the mix, so to speak, in the years to come.

BARBARA NICHOLS (Wisconsin): I would like to share the insight that I have gained. I cannot speak as to whether or not the non-nurses on our board are confused in terms of the different levels for the preparation of practitioners. But, I would say that in my appearances

before the legislature there is much confusion. I usually make a statement relative to the fact that I am the president of the Wisconsin Nurses' Association and a practicing nurse. Then legislators would ask me, at the end of my presentation, if I was a practical nurse. I think, to a degree, that reflects confusion on the part of the public in terms of the jargon that we use. Therefore, I think, perhaps, we should be careful about how we interchange the words practitioner, practical nurse and practicing nurse. It is very clear when the doctor says he is a practicing physician, but the word is not so clear when the nurse says she is a practicing nurse.

JEAN BOWEN (Connecticut): I happen to be very much in favor of Dr. Peplau's suggestion. I think it is urgent.

I also would like to support the last speaker's statement. I attended a convention of the legislature last fall to speak against a bill that was being introduced in Connecticut to change the makeup of the State Board of Nursing Examiners. The chief objection that I had to this bill was that they had very clearly defined what the preparation of the nurse should be. She should be associated with the institution of higher learning or working in the hospital. However, for the laymen or the professional people on the board, there were no criteria set down. In asking the legislators who were submitting the bill why they did not have any criteria for admission for the non-professional or the other professionals, they frankly admitted they did not know how the bill was being introduced. They were very embarrassed at this point and were looking for other avenues of more or less escape.

I think it is true that the legislators are not familiar with the profession. I think we need to talk more and more to them. Also I would ask ANA to state more clearly what kind of criteria we want for non-members and the allied professionals.

(A brief recess was then taken.)

MISS PEEPLES: I would like to say that it is not always easy, being a public official, to meet everybody's expectations. So frequently and ever since I have associated with the Board of Nursing, the subject continues to come up about who is to be appointed to the board. When the governor makes an appointment, there are disappointments. Some people are unhappy and make their criticisms known.

I would like to mention that when a person is appointed to a board of nursing, that individual takes an oath of office which is binding. That person must assume the responsibilities of that office which requires much time and hard work. Often individuals express a desire to be a member of the board. Then when they get appointed, they do not want to spend the time that is necessary to do the job at hand. I would suggest for your consideration, because this is really an important issue in my view, that State Boards of Nursing and State Nurses' Associations get together and decide who would be the best board member or members and then get these requests to the governor.

I have found that governors are reasonable people. They will listen to you because the success of the agency is the governor's success. So it is not always what we do, it is how we do it. I have lived through six or seven governors from both parties. We have gone through government reorganization. I have still always been able to get to the governor. I think it is how we go about it that counts.

You may wish to consider the following example in regard to changing your law to limit the number of terms of office for a board member. I believe it was during President Truman's administration, when Congress was considering limiting the terms that a President may serve, that the Congress exempted the President who was in office from that stipulation. The reasoning behind this I believe was that the legislators did not wish to deal in personalities.

I would like to leave one more thought with you. When boards of nursing are not successful and do not do their job well, they do not stay in the positions to which they are appointed. Those that are successful, in most instances, will maintain, which makes for continuity. It is in the best interest of the public in some instances.

If we can all put our shoulder to the wheel and resolve our differences and come together and view our issues objectively, then we can and will fulfill our obligations to society. The public's interest must come first in thinking of appointments to boards of nursing.

SARA ERRICKSON (New Jersey): I do believe that continuity in service in any area is most important. There is no doubt in my mind that many nurses have served very well on our State Board on behalf of the public. But, I do believe that if a nurse serves five or ten years, although she is providing very good service on behalf of the public, I think that it is time for her to move on and let some other younger people get the experience.

MISS HASTINGS: I would like to clarify for you that the concerns expressed by Dr. Peplau will be referred to the Executive Committee of the Council of State Boards of Nursing for consideration.

FREE DISCUSSION

HELEN KEEFE (Florida): In California, how are they coming along in implementing their law in relation to continuing education?

MICHAEL BUGGY (California): As you know, we have a mandatory continuing education bill in California that goes into effect in 1975. We have 151,000 registered nurses in California and about 50,000 LVNs. The mandatory continuing education affects only those two licensing agencies. The vocational nurses' renewal period is every two years, so they will have problems at renewal time trying to evaluate the continuing education offerings that are submitted. We renew on a cyclical basis. If you are not familiar with that term, it means that we renew on the licensee's birth date every two years. So we renew every day, and we have on an average of 400 to 500 renewal applications a day or roughly 2,000 a week.

The bill provides that the Director of the Department of Consumer Affairs shall appoint a council on continuing education, of which he is chairman. The council is made up of one registered nurse, one LVN, a hospital administrator and a public consumer. Maryellen Wood, the executive of the LVN Board, and I are concerned about implementing this aspect of the law. Maryelien and I went to the Director of the Department of Consumer Affairs and asked what he intended to do about appointing this council. I said that I had to know by January, 1973, what the council will accept as continuing education, so that nurses between

1973 and 1975 will be able to prepare themselves to meet whatever is the law in 1975.

One of the administrative problems is that the council will review the continuing education programs. When they have reviewed the programs, they will tell me what I can accept and what I cannot accept. The Director was surprised when we told him the number of educational institutions in the state, the number of hospitals in the state that probably would be offering in-service education programs that would require approval and the estimated number of commercial schools. So he immediately appointed someone to work on this.

Incidentally, the courses identified in the act are in-service programs in hospitals, college programs, seminars, workshops and home study courses. How the council is going to evaluate these is a mystery to me.

Maryellen and I have concerns about how to do the internal bookkeeping. There were two possibilities that we identified. One would be to get some evidence that the course was taken — a transcript or a receipt. I met with people who work with the computers. We thought about including on the back of the renewal application card a statement verifying and signed under perjury, that the nurse did take whatever course was identified. That would be one way of handling it.

The other possibility of implementing this was to get a receipt or a transcript and put it into the licensee's folder. This would mean a lot of massaging and rechecking of the 151,000 folders. Our office is not large enough to house all of the folders. We have most of them in archieves three miles away in West Sacramento. It takes three days to get them to our office when we require them. I think we got the message to him of the magnitude of implementing the program and the kind of work that the council will have.

My personal feeling is that as professional people we should not have to have something like this mandated to us. It is our individual responsibility, as a professional person, to keep ourselves current. To get a piece of legislation like this, I think, is kind of insulting to the profession. But, recognizing people are human, we have it.

As I think it through now, the idea of putting a statement on the back of the renewal notice is probably the cleanest way of handling the situation. We would keep those on file.

The law provides that, if you wish, you can let your license lapse for a period of eight years. However, evidence of continuing education must be submitted when the license is renewed within the eight-year period. If a license is lapsed more than eight years, the nurse is required to repeat the licensing examination, the State Board Test Pool Examination.

MARJORIE NEFF (Nevada): We are concerned in Nevada because we have a goodly number of people who are also licensed in California. What kinds of provisions are going to be made for those of us who are in Nevada or some place else? Would you accept continuing education credits or courses from other states?

MR. BUGGY: That is a whole new ball game. One day last week I got a call from a nurse in Nevada. She said they had had a district nurses' meeting the night before and talked about continuing education. When the question was asked as to how many in the room had a license in California, more than ninety percent of that group indicated that they had a California license. She wanted to know if California would approve a course offered by the University of Nevada. I said that I could not answer that question. It would seem that for licensees living outside of California and writing to take a continuing education program to meet the California requirements, the institution offering the course would have to go through the same process as the schools in California. So you can see now what volume this is going to have.

ELEANOR SMITH (Virginia): In this past year I heard someone make the comment that nurses constitute the largest group of migrant workers in the United States. I subscribe to that wholeheartedly. I would like to ask, what are the plans for nurses who apply for California license by endorsement?

MR. BUGGY: That is a good question. Because of our biennial renewal system on birth dates; it is possible to have a two-year grace period until the next licensure comes up. The nurse who is endorsed will have to meet continuing education standards at that time. However, depending on when the birth date falls, the nurse may have two years' grace, one year's grace, or one month.

MISS SMITH: Another thing the council should take into consideration is the relevance of the continuing education courses to the practice that the person is engaged in.

MR. BUGGY: My background and preparation is in psychiatric nursing. I personally feel that I am not prepared to practice the way I was seven years ago. However, I have to have a license for this job. So if I want to update my skills in my professional practice, I would like to take a course in psychiatry to meet my requirements for continuing education. Do I take the course in nursing or do I take the course in management?

We talked about the problem of the nurse who is in the intensive cardiac care unit and takes a course there, then is changed to the pediatric unit where she does not feel skilled. Does she then submit another course in that area? There are all kinds of problems with nurses moving from one area of nursing to another. Then you have the float nurse who changes areas every day.

I was talking to a group of nurses three days after the governor signed the bill. They were in-service educational directors in the northern part of the state who asked how this thing ever got passed. One director was concerned that one registered nurse would solely determine what the current standards of practice for nursing would be for 151,000 nurses in California. I explained that there would be one registered nurse, one LVN, one hospital administrator and a public member to determine this.

REBECCA CULPEPPER (Tennessee): You made reference to the volume of work in response to the question from Nevada. Did you not indicate that there would be the concept of prior and subsequent approval of courses in relation to this matter of continuing education versus the concept in which you approved course by course offerings?

I think we need to seriously consider the concept of approval of continuing education offerings. It seems to me that we have picked up some models from some very small professional groups, in some instances, on approval on a case-by-case basis. I think you have demonstrated the magnitude of the problem when you talk about individual courses.

There is another model available which we are very hesitant to look at because we sometimes think they are out to do us in. That group is medicine. They have an approval system for continuing education programs. What they are doing is approving the agency that will offer the continuing education courses. Knowing that the structure is there will safeguard the educational component of any course they offer.

In Tennessee we have had considerable discussion of this concept. We have had some consultation in terms of project grants. One thing we bumped up against, in terms of an agency approval in relation to continuing education program offerings, was that nobody will buy this. It is contrary to everything that has ever been talked about.

What authority, legal right or anything else do you have? I brought up the question of accreditation of basic programs. The answer I received was that nursing will never buy this.

I think we have to take a serious look at whether we can afford, as the largest group of deliverers of health care in this country, to add this business of a case-by-case review of course offerings. I submit we need to take hard looks at what the ramifications might be if the public demands the same kinds of laws in other places as you have in California. We may be up against realities of doing things we do not want to do. If so, how are we going to cope with it?

MR. BUGGY: I think your point is well taken. I think that it might be a possibility to approve institutions rather than individual courses. This might make the workload easier.

LORNA POSSEY (Mississippi): I would like to ask if you will accept continuing education from other states? For example, if Michigan had a law regarding continuing education, would you accept that as a basis for issuing a license in California?

MR. BUGGY: I do not know. At this stage, that has not come up. I would be inclined to guess that probably it would be accepted. Much as the license by reciprocity is accepted, the continuing education for that license on the reciprocity basis would be accepted. Now, that is just speculation.

VOICE: I am curious to know if the Council on Continuing Education in your state has contemplated measurability in relation to credits, semester credit hours or just number of hours for each of these courses that would be acceptable?

MR. BUGGY: The council has not yet been appointed. They will not be appointed until July as the law requires.

We have talked about the units as compared to the course hours. We talked about counting units, counting hours. Because of what we think the volume might be, we were thinking in terms of approving the course rather than the hours because the council is not large enough, nor do they have the staff to sit down and review and count numbers.

I hope that the council will just approve courses. I hope I do not have to get into the problem of counting units or hours. I have mentioned that we renew 400 to 500 licenses a day. I have one clerk that handles that volume. The process, now, is merely taking the money off the application and processing the money. If I have to have staff look at the transcript and count credits or hours, I am going to need another whole office just for that.

One of the problems that we will be running into is the person who takes a course that was not approved by the council. A person may not care what the council said and takes the course that he thinks will help him most. That means that his license could not be renewed in California where we have the mandatory license. You can see the volume of complaint letters that kind of action will stimulate. The part of the office that handles the complaint letters will see its volume going up.

CARMEN ROSS (Florida): I was very actively involved in planning educational programs which involved physicians as well as others. Being located in Miami Beach, we would have registration, sometimes, of 500 or 600 persons. However, when the program started, sometimes there were as few as twelve in the audience.

MR. BUGGY: I think that we have experienced this in nursing, especially with the nurse from another country who has to make up deficiencies. Schools would make the effort to develop a special course for these people and, say there were fifty foreign nurses in the area, maybe two would show up.

KIMI HARA (Minnesota): I think that all of us are certainly in agreement with the philosophy of continuing education for renewal of license. I also feel that, as in California, there are many problems that are in the law that must be complied with.

I do know that many states are currently working on continuing education projects and trying to see what would be the most feasible. This leads me to say that there is a much greater need for state associations and boards of nursing to get together.

We in Minnesota have a full-time MNA legislative representative during the years between sessions. She keeps us informed. We keep her informed as to what possible changes there might be in the coming legislative session. Without that sort of working relationship, I do not think that however good you think your proposed continuing education program is, when it comes to implementing or meeting a deadline date, if it is not agreeable to the people who are serving the public, it is not going to be very effective.

I am urging that boards of nursing get together with the Association's legislative representative to prevent the passage of poor legislation in relation to continuing education.

MR. BUGGY: I will second that. Yesterday we repeatedly heard about the numbers of nurses and we are the largest number of health care workers in the country. Yet in California, with its large number of nurses, they are the least effective group in the legislature. I think it has been tradition that nurses feel that they do not have to get involved in legislation or politics. But, I feel strongly that we are at a point in history that if we do not take the initiative to become informed and involved in the politics and in legislation affecting health care, nurses will fall by the wayside. We will no longer be the health care group that we are identified as now.

LYNNE ILLES (Iowa): Would you share with us, for information only, any discussion thus far about how this bill may influence nursing manpower in your state when some move out of the nursing profession because of fear to take this continuing education?

MR. BUGGY: The fears that have been expressed I think mostly came from the rural areas where they felt

that they had to go back to an academic institution to meet the requirements of the law. It seems that this same thought comes into most of the nurses' minds. That is not necessarily so.

I suspect, too, that there is a large number of nurses in California who are not practicing, but they would like to keep their license renewed for sentimental reasons. Those people, I am sure, would be wounded by this piece of legislation. So that segment of the licensed population will drop. The other segment includes the mother raising a family. She might choose to drop out and take the advantage of the seven to eight year lapse. We might find, I think, a drop with that group.

This situation would cause a problem with finances. Revenue would drop. We have a special fund in California. We do not contribute to the general fund, nor do we get anything from it. We maintain ourselves strictly on the fees that we receive from our licensees. Two years ago, in anticipation of this bill going through, I had asked the board to increase our fees from $6 to $8 every two years. Many of the older nurses complained to me that this was a hardship on them since they were on Social Security and they could not afford this increase. My anticipation was that, if the bill went through, two segments of nurses would not renew and our revenue would go down. With the increase that I had asked for and got, I think it might balance out.

SISTER CAROLITA (Utah): How did the legislation get through in the first place? Where were the nurses when this happened?

If you think you have problems now, wait until you start to enforce this. In Utah, as you may know, we have a voluntary continuing education program. I did not know how nurses could get up in arms until after the organization adopted it. The situation taught me a lesson about getting nurses involved in the critical issues before they are voted on at convention or in the legislature.

Also, we are talking about continuing education credits and whether the courses will be accepted or not. You should realize what a load this is going to put on your professional organization. The responsibility of affording the opportunities for these people to acquire the necessary credits in order to get their license renewed may also fall to the organization. Believe me, the state board cannot provide this. At least in the way state boards are presently set up, there is no possible way that they can provide this.

Who does it fall back on? It falls back on the professional organization; all of us constituents. So, you presidents and executive directors better go home with the idea that if this is adopted in your state, the responsibility is going to fall on your shoulders. When you speak of the rural, I do not think you can be any more rural than we are in Utah. We have very few nurses compared to California, but we have to go down to hospitals in areas where the total nurse population in that area is present for our programs. There may be six nurses. That is the total nurse population. We have to see to it, as a professional organization, that we reach those nurses. They cannot come to Salt Lake City or Ogden or Provo which are the only three areas in the whole state which offer these types of programs.

We do have some small colleges in these areas, but they do not have continuing education programs that you can go through. Therefore, even if you do use the continuing education program from your colleges, in some of these states you are going to have to get this operating through your professional organization.

Now, although we keep talking about all the courses and everything, the other big issue here is what are we going to be able to do to assure competency? This is a critical issue right now. Nurses can take all the courses in the world, but what are you, as professional organizations, going to do to apply pressure to help agencies provide the type of program for their nurses that will insure competency?

The one thing we are doing, for example, at our own hospital, Holy Cross, is to set up standards of practice for each area of nursing: pediatrics, operating room, coronary care, intensive care, et cetera. The nurses, not the directors of nursing, but the nurses working in these areas, are setting up standards of practice which will be part of the orientation. Once a year we have our own continuing education program that they must go through in order to assure us of their competency.

That is only one way to approach it, but it is something that you can all take back and think about and work from there. When you start to realize the terrific ramifications that this kind of program has in your state, you are really going to have to get together and work as a professional organization and as a group of nurses to put a program like this into effect. It will be to the best advantage of all your nurses and better patient care will result.

MR. BUGGY: I would strongly urge all of you to hold off any kind of continuing education that would be legislated. I think there are too many questions and too many problems, as Sister has identified, that need to be clarified and worked through before we get into any kind of a mandatory thing. Those are the problems I tried to identify and I am sure I have not identified all of them. I probably will not find them until I put things into practice. I think we need time to work through the particular problems of our states — the geographic problems and the social problems of that geography.

MARGARET SULLIVAN (Washington): In Washington, as you heard earlier this morning, we did study our law. We had ten statewide conferences to bring the nurses up to the point where, at least, they knew that we did have a law and what it has contained. I think this was an eye-opener for many to find out that the majority of nurses really were not familiar with what was in the law and what the responsibilities of the board of nursing were versus the professional association.

To repeat, one of the concepts that was accepted by the Washington SNA House of Delegates was that of continuing education. I have served on the committee that was working on this law and very purposefully kept quiet as to the implementation. When people would say, Margaret, how are you going to implement this? I said I could not worry about that right now because many things could happen between now and when we go to the session of the legislature in 1973.

We have had a very excellent working relationship between our Board and the State Nurses' Association. We feel free to contact each other on any problem. For example, the committee that has been working on the revisions of the law will be meeting with our Board of Nursing, when we get back from this meeting, to start hashing over some of the nitty-gritty problems in terms of writing this for legislation action.

The other thing that has concerned me about all this is how is continuing education going to meet the primary responsibility of any licensing law in terms of the protection, safety and welfare of the people? Is this really going to improve nursing care? I think that is the issue we have to speak to.

VIRGINIA HILDEBRAND (Oregon): I am disappointed that I have not heard more about how the public is going to be protected by continuing education. Sister struck on the chord. We did not have the money. The Emergency Board of the Oregon Legislature has awarded me $20,000 for a continuing education project, so I am looking for a director.

GENEVIEVE JONES (Georgia): I think there are two things that I still have not heard discussed. One is the cost of continuing education for the nurse. One of the observations that I have made is that registration fees are going up. Once you could go to a program with no registration fee or it would be $1 or $2. Now I see that these registration fees are up to $10, $30, $50. So, I think that this "get the money" thing is always around and as we look at this area of continuing education, I think we should look at the cost, not only to those of us who are trying to implement it, but also the cost to the people who are going to have to do something about it.

I also heard a reference to the purpose of continuing education. Somewhere along the line I think we need a clear-cut statement of why we are doing it. Are we doing it in order to perpetuate some fund raising group somewhere, assure competency, or to say the patients will get better nursing care?

MR. BUGGY: I think I can speak with assurance, in relation to California, that the state is concerned about the real concept of continuing education rather than about any kind of commercialism.

MRS. JONES: I do not think it is always necessary to have somebody else say how competent we are. I think there is an area of self-evaluation.

ANNE ZIMMERMAN (Illinois): May I comment about the relationship of institutional licensure to continuing education?

The concept of institutional licensure is to remove the responsibility of an institution from having to comply with the laws for individual licensure and to set up its own criteria through job descriptions and qualifications. Therefore, any tie-in between continuing education and individual licensure will be nonexistent if the institution is able to avoid the necessity for complying with individual licensing laws.

I submit again, as I tried to yesterday, that the DHEW project, which undoubtedly will be funded, does test the capability of the institution to credential its own personnel and will seek to have an exemption from this provision. Therefore, I think that this is at least as important as whether or not continuing education should be mandatory or permissive, because it may, in the long run, not matter which it is, if there is institutional licensure.

MR. BUGGY: I would like to tell you now, before we close, that there are several pieces of legislation introduced this year in California with regard to continuing education. One is that the council members would be increased from one RN and one LVN to five RNs and five LVNs. Another piece of legislation provides for an appeal to the council. So, if you feel that the course you took was better than the one they offered, you can appeal to the council. That means the council would have to set up administrative hearings according to California law and function like a state board in giving you an opportunity to be heard; then developing regulations. So then you will have another kind of nursing board. There is also legislation that says if this (continuing education) presents hardship to the nurse, she does not have to do it.

CHAIRMAN HASTINGS: I am sure that you will all join me in thanking Michael Buggy for sharing with us so candidly the situation in California.

On behalf of the Council of the State Boards of Nursing may we wish you all bon voyage and a very busy year — dedicated to all those activities which will enhance the care of the people for whom we have a responsibility in the years to come.

(At 12:01 p.m. the conference was adjourned.)